Patient Advisory and Acknowledgement

Receiving Dental Treatment During the COVID-19 pandemic

Name: _____ Date: _____ Temperature_____

Please be advised that while our office complies with the State Health Department and Centers for Disease Control and Prevention with guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including our patients) could be infected, with or without their knowledge. In order to reduce the risk of spreading COVID-19, we are asking the screening questions below and we ask that you be truthful and candid in your answers.

In the past month have you experienced:

1. A fever or flu-like symptoms?	YES	NO
2.Shortness of breath?	YES	NO
3.Dry cough or sore throat?	YES	NO
4.Runny nose?	YES	NO
5.Notice a change/loss of taste or smell?	YES	NO
6.pink eye or conjunctivitis?	YES	NO
7.Have you been COVID-19 positive or being with someone who has?	YES	NO
8.Have you travelled to any foreign country?	YES	NO
if so, where_____		
9.Have you travelled within the United States?	YES	NO
if so, where_____		
10.Have you visited a hospital?	YES	NO
11.Have you visited an Assisted living or Senior Center?	YES	NO
12.Have you been in a gathering of more than 10 people?	YES	NO

PATIENT/RESPONSIBLE PARTY: _____DATE: _____