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COVID-19 PATIENT QUESTIONNAIRE

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful.

Also note that immunocompromised conditions including but not limited to radiation, chemotherapy, lung diseases such as asthma, COPD, diabetes, heart or kidney disease and autoimmune disorders may put you at a higher risk for contracting COVID-19. Please disclose any conditions that may put you at a higher risk and we may ask you to consider rescheduling your dental treatment.

	YES	NO
DO YOU HAVE A FEVER OR HAVE YOU FELT HOT OR FEVERISH RECENTLY (14-21 DAYS)?		
DO YOU HAVE ANY SHORTNESS OF BREATH OR DIFFICULTY BREATHING?		
DO YOU HAVE A DRY COUGH?		
DO YOU HAVE A RUNNY NOSE?		
DO YOU HAVE A SORE THROAT?		
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?		
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?		
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?		
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?		
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?		
HAVE YOU TESTED POSITIVE FOR COVID-19 OR IN CONTACT WITH ANY CONFIRMED COVID-19 POSITIVE PATIENTS?		
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history. As a courtesy, please inform the office if you or anybody in your immediate household has tested positive for COVID-19 within 14 days of your visit to our office.

I acknowledge that the answers I provided above are true and accurate.

Patient Name

_____

Patient Date of Birth

_____

Signature of Parent/Patient

_____

Date

_____

Office Use Only

Temperature
Patient _____
Parent/Guardian _____

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Healthy Smiles Begin Here!

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PATIENT CONSENT
DENTAL TREATMENT IN THE ERA OF COVID-19

Our goal is to provide dental treatment in a safe environment for our patients and staff while we continue to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

As with the transmission of any communicable disease like the cold or the flu, you may be exposed to COVID-19, also known as the "coronavirus" at any time or any place. Be assured that we continue to follow state and federal regulations as well as well as the utilization of universal personal protective equipment (PPE) and enhanced disinfection protocols to limit transmission of all diseases in our office.

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 other patients) could be infected, with or without their knowledge.

Despite our careful attention to sterilization, disinfection, and the use of personal barriers and PPE, there is still a chance that you could be exposed to an illness in our office, just as you might be exposed in your gym, grocery store or your favorite restaurant.

The practice of social distancing that has taken effect nationwide has significantly reduced the transmission of the coronavirus. We have followed the same social distancing practices at the dental office although it is not possible to maintain the necessary distance between our dental staff and the patients due to the nature of dental treatment. Despite the increase in regulation and safeguards to ensure patient safety, there is the relatively low risk of infection considering a mask cannot be worn by the patient during treatment.

I confirm that I have read the above information and fully understand the risks and possibility of contracting COVID-19 in the dental office. I understand and accept the additional risk and also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my dental visit.

Thank you for your continued trust in our practice.

Patient Name

Patient Date of Birth

_____ _____

Signature

Date

_____ _____