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Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control 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 other patients) could be infected, with or without their knowledge.

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 and candidin your answers.

_____ _____

PATIENT RESPONSIBLE PARTY DATE

PLEASE ANSWER "YES" OR " NO" WITH YOUR INTITIALS, TO THE FOLLOWING QUESTION:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	YES NO initials ___
DO YOU HAVE A FEVER?	YES NO Initials ___
DO YOU HAVE ANY SHORTNESS OF BREATH?	YES NO Initials____
DO YOU HAVE A DRY COUGH?	YES NO initials ____
DO YOU HAVE A RUNNY NOSE?	YES NO Initials____
DO YOU HAVE A SORE THROAT?	YES NO Initials____
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE	
THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	YES NO Initialis ___
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	YES NO Initials ____
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	YES NO Initials ___
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	YES NO Initials_____
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	YES NO Initials____

IF SO, WHERE? _____

Patient Signature_____ Date _____