Patient Advisory and Acknowledgement

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 the 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 are asking you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid with your answers.

PATIENT/RESPONSIBLE PARTY_____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____YES _____NO
DO YOU HAVE A FEVER?	_____YES _____NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____YES _____NO
DO YOU HAVE A DRY COUGH?	_____YES _____NO
DO YOU HAVE A RUNNY NOSE?	_____YES _____NO
DO YOU HAVE A SORE THROAT?	_____YES _____NO
ARE YOU SNEEZING, HAVE WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____YES _____NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____YES _____NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____YES _____NO
WITHIN THE LAST 14 DAYS, HAVE YOUR TRAVELLED TO ANY FOREIGN COUNTRY?	_____YES _____NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	_____YES _____NO

IF SO, WHERE? _____