Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have presented to the office today for treatment while the COVID-19 pandemic persists. 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 candid in your answers.

PATIENT/RESPONSIBLE PARTY **DATE**

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

HAVE YOU HAD A FEVER OR FELT HOT OR FEVERISH IN THE LAST 14-21 DAYS? _____YES _____NO

HAVE YOU EXPERIENCED SHORTNESS OF BREATH, OR OTHER DIFFICULTIES BREATHING IN THE LAST 14-21 DAYS? _____YES _____NO

DO YOU, OR HAVE YOU HAD A COUGH IN THE LAST 14-21 DAYS? _____YES _____NO

ANY OTHER FLU-LIKE SYMPTOMS SUCH AS GASTROINTESTINAL UPSET, HEADACHE OR FATIUE IN THE LAST 14-21 DAYS? _____YES _____NO

HAVE YOU EXPERIENCED A RECENT LOSS OF TASTE OR SMELL? _____YES _____NO

HAVE YOU BEEN IN CONTACT WITH ANY CONFIRMED COVID-19 POSITIVE PEOPLE? _____YES _____NO

ARE YOU OVER 60? _____YES _____NO

DO YOU HAVE HEART DISEASE, LUNG DISEASE, KIDNEY DISEASE, DIABETES, OR ANY AUTO-IMMUNE DISORDERS? _____YRS _____NO

HAVE YOU TRAVELLED, OR HAS ANYONE YOU LIVE WITH, TRAVELLED AWAY FROM YOUR HOME IN THE LAST 14 DAYS? _____YES _____NO

IF SO, WHERE?_____