Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routing 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 spread 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.

Additionally, if you experience any COVID-19 symptoms in the 14 days following treatment, please contact our office so that we may take appropriate precautions to protect ourselves and other patients.

____ ____________________

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 breathing?	___ 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
Do you have sneezing, 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

Patient Signature____

Date____