Patient Advisory and Acknowledgement Receiving Dental Treatment and Exposure Risks

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 COVID-19 virus, we cannot make any guarantees.   Our staff is symptom-free, and to the best of their knowledge, has 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 thier 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.

Does the patient currently have, or in the past 72 hours, a fever over 100.4º?	▢ Yes ▢ No
Does the patient have any shortness of breath?	▢ Yes ▢ No
Does the patient have a dry cough?	▢ Yes ▢ No
Does the patient have a sore throat?	▢ Yes ▢ No
Does the patient have a runny nose?	▢ Yes ▢ No
Does the patient have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?	▢ Yes ▢ No
Has the patient experienced headache, fatigue or weakness?	▢ Yes ▢ No
Has the patient had any changes to or loss of sense of taste/smell?	▢ Yes ▢ No
Does the patient have any GI symptoms? Diarrhea? Nausea?	▢ Yes ▢ No
Is the patient currently awaiting the results of a COVID-19 test?	▢ Yes ▢ No
Has the patient been in contact with anyone that has tested positive, presumed positive, or under investigation for COVID-19 in the past 14 days?	▢ Yes ▢ No
Does anyone in the patient’s household currently have, or in the past 72 hours, a fever over 100.4º?	▢ Yes ▢ No
Within the past 14 days, has the patient travelled to any foriegn country?	▢ Yes ▢ No
Within the past 14 days, has the patient travelled within the United States?	▢ Yes ▢ No

If so, where? ____

Acknowledgment

I authorize and give consent for the completion of planned dental care to my child, any changes to planned treatment as deemed necessary or advisable in the care of a minor child.

By signing this form you acknowledge and accept the risk of exposure in our office to a communicable disease, included but not limited to COVID-19. I have read, understand, and give my consent as stipulated above. My signature means that I have read this form, understand the contents and agree.

____
Printed Name

____
Relationship to patient

____
Signature

____
Date