Patient Advisory and Acknowledgement Concerning COVID-19

Dear Patient:

Welcome to our office today for your dental exam and treatment. Please be advised of the following:

1. Our office complies with State Health Department and the Centers for Disease Control and Prevention (CDC) infection control guidelines to prevent the spread of the COVID-19 virus. Our dental providers use face masks, face shields, and other personal protective equipment (PPE) and thoroughly disinfect equipment and surfaces. While we take extensive measures to prevent the spread of the COVID-19 virus, we cannot provide absolute guarantees.
2. Our staff are symptom-free. However, since we are a place of public accommodation, other persons (including other patients) could be infected without their knowledge. We attempt to maintain distancing between patients in the waiting room, check-in, and check out. We kindly ask that you maintain at least 6 feet distance from other patients and wear a face covering when not seated in the dental chair.

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 NAME: ____ TEMPERATURE TODAY: ____________________

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

(If you have tested negative, please provide a copy of your test result)

HAVE YOU RECEIVED A POSTIVE COVID -19 TEST? IF YES WHEN? ____________ ______YES ______NO

ARE YOU IN CONTACT WITH ANYONE WHO HAS BEEN CONFIRMED TO BE COVID-19 POSITIVE? _______YES______NO

DO YOU HAVE A FEVER OR HAVE YOU FELT FEVERISH RECENTLY? _______YES______NO

DO YOU HAVE ANY SHORTNESS OF BREATH OR A COUGH? _______YES______NO

DO YOU HAVE A RUNNY NOSE OR SORE THROAT? _______YES______NO

HAVE YOU LOST YOUR SENSE OR TASTE AND/OR SMELL? _______YES______NO

DO YOU HAVE ANY SNEEZING, WATERY EYES, OR SINUS PRESSURE NOT

RELATED TO SEASONAL ALLERGIES? _______YES______NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? _______YES______NO

SIGNATURE: ___________________________________ DATE: ______________________________