

Patient Advisory and Acknowledgment

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 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:

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| 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 |
| 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 |
| WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY? | _____ YES | _____ NO |
| WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES? | _____ YES | _____ NO |
| IF SO, WHERE? | _____ | _____ |