Patient Advisory and Acknowledgment
Receiving Dental Treatment During the COVID-19 Pandemic

Dear Parent and Patient:

You have presented to the office today because you have a dental condition which must be treated at this time and cannot be postponed until the current COVID-19 risk period abates.
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 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 THE FOLLOWING QUESTIONS:	PRE-APPOINTMENT	IN- OFFICE
	DATE:	**DATE:**
Do you/they have a fever or have you/they felt hot or feverish recently (12-14 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID - 19 positive patients?	☐ Yes ☐ No	☐ Yes ☐ No
Is you/they age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, kidnet disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No
IF SO, WHERE? _____		