

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

Dear Patient,

You are scheduled to come to our office today for dental treatment that will be done during the COVID-19 pandemic.

Please be aware the following:

- Our office complies with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the virus
- Our staff are symptom-free and to the best of their knowledge have not been exposed to the virus.

In order to reduce the risk of spreading COVID-19, we have a number of “screening” questions below. For the safety of our staff, other patient, and yourself. Please be truthful and candid in your answers.

Do you have any of the following COVID-19 risk factors:

- | | |
|--|--|
| <input type="checkbox"/> Over 65 | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Lung condition | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Immune compromised (HIV, cancer, other) | <input type="checkbox"/> Diabetes |

Have you tested positive for COVID-19? Yes No

Are you currently awaiting the results of a COVID-19 test? Yes No

Have you been in close contact with someone who has been ill, had a fever, or tested positive for COVID-19 in the last 14 days? Yes No

Have you had a change to your sense of taste and/or smell? Yes No

Are you experiencing any of the following flu-like symptoms?

Fever

Nausea/vomiting

Chills

Sore throat

Diarrhea

Shortness of breath

Headaches, fatigue, or weakness

Dry cough

Patient Current Temperature

I have interviewed the patient and confirm that they are approved to receive dental treatment:

I certify that all information provided is true and correct, and I consent to receive treatment in the COVID environment:

Employee Signature

Patient Signature

Employee Name

Patient Name

Date

Date