Patient Advisory and Acknowledgment Receiving Dental Treatment

Patient Name _____ Date_____
Parent / Guardian if applicable _____

In order to reduce the risk of spreading COVID 19, please complete a number of screening questions below. **For the safety of our team, other patients, and yourself, please be truthful and candid in your answers.**

Have ***you or anyone close to you*** experienced any signs or symptoms of COVID-19 within the past 14 - 21 days such as:

Cough – wet or dry	_____yes	_____no
Fever or felt hot / feverish	_____yes	_____no
Shortness of Breath / Difficulty Breathing	_____yes	_____no
Sore Throat	_____yes	_____no
Muscle/Body Aches	_____yes	_____no
Nausea/Vomiting/Stomach upset	_____yes	_____no
Fatigue or Headache	_____yes	_____no
A recent loss of taste or smell	_____yes	_____no
Runny Nose	_____yes	_____no

Have ***you or anyone close to you*** traveled out of state or outside of the country within the last 21 days? If yes, where?

_____

Have you come into contact with anyone who has tested positive for COVID-19 or has had suspected exposure to COVID-19?
_____yes _____no
Have you been within close proximity (<6 feet space) at a gathering of more than 10 people _____yes_____no

Have you been tested for COVID-19, with either a positive or negative result? _____yes _____no

Do you have an autoimmune disorder or are on an immune suppressing medication or steroids? _____yes _____no

Have you been diagnosed and /or treated for heart disease, lung related disease, kidney disease, cancer, diabetes or autoimmune disorder? _____yes _____no If yes, please specify:

_____

Do you currently smoke or vape or have you stopped those activities within the past 2 years? _____yes _____no

Is the caregiver for the patient at today's appointment over the age of 65? _____yes _____no

Our practice complies with State Health Department and the CDC infection control guidelines to prevent the spread of the COVID-19 virus; however, we cannot make any guarantees. Our team is screened daily and, to the best of their knowledge, have not been exposed to the virus. We are taking precautions to limit the spread of any potential disease, yet there is still a possibility of transmission. We are a place of public accommodation, and other persons (including other patients) could be infected, with or without their knowledge. I hereby knowingly and willingly consent to have dental treatment completed at this time. I will hold harmless and indemnify, the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions, in exchange for dental treatment during the events of COVID-19 National Emergency. I make this decision of my own free will relying upon my knowledge and judgement of any injury I may have sustained or possible transmission of COVID-19 during treatment and my decision to release has not been affected by any false statements or representations pertaining to those injuries. I have carefully read this release and understand its contents, and I am signing it of my own free act.

Patient Name _____Date _____

Patient or Parent / Guardian Signature_____

Team Member Signature _____