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Covid-19 Patient Screening and Consent Form

Patient's Name:_____

Date of Birth:_____

Do you or your family member have any of the following symptoms?	**In-Office**
Fever above-normal temperature (> 100.4 F)? Take temperature at appointment.	☐ Yes ☐ No
Chills?	☐ Yes ☐ No
Cough?	☐ Yes ☐ No
Sore Throat?	☐ Yes ☐ No
Shortness of Breath and/or Trouble Breathing?	☐ Yes ☐ No
Persistent Pain, Pressure or Tightness in the Chest?	☐ Yes ☐ No
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ Yes ☐ No
Have you or other accompanying you to today's appointment traveled outside of our local area or outside of USA within the last 14 days?	☐ Yes ☐ No
Have you been tested for COVID-19 in the last 14 days? If "no", proceed to next question.	☐ Yes ☐ No
If Yes, what is the result of the testing?	☐ Positive ☐ Negative
If still waiting on results, schedule appointment after results are known.	☐ Positive ☐ Negative

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. The COVID-19 virus is a contagious disease classified by The World Health Organization as a pandemic. It's possible to contract COVID-19 from a variety of sources.

We've taken steps to reduce the possibility of transmitting disease in our office, including COVID-19. Our air purification systems, High Volume Evacuation, sterilization procedures, and use of Personal Protective Equipment lower the risk of disease contraction in our setting. It does not eliminate the risk.

I understand and accept the risks associated with contracting COVID-19 from dental care in this office. I also acknowledge that I could contract the COVID-19 virus before or after my visit from other sources. I agree to continue with my dental care.

Patient's or Guardian's Signature **Date**