Patient Advisory and Acknowledgment Receiving Dental Treatment

Patient Name ________________________________ Date _____________________________

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 flu-like symptoms 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 you have come in contact with, traveled out of state or outside of the country within the last 21 days? If yes, where?

____

Have you come in contact with anyone who has tested positive for COVID-19? ________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

Persons over 65 are at a higher risk. Are you 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 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 Signature_______________________________ Witness Signature _________________________