PATIENT ADVISORY AND ACKNOWLEDGMENT
FOR RECEIVING DENTAL TREATMENT DURING THE COVID-19 PANDEMIC

As a valued patient, you have come to our practice today for dental evaluation and/or treatment that will be completed during the COVID-19 pandemic. Please be advised of the following.

While our office continues to implement the appropriate recommendations from the State Health Department and Centers for Disease Control and Prevention (CDC), as regards infection prevention, control, and to prevent the spread of the Coronavirus; and, because we are a place of public accommodation, other persons in the office (including other patients) could be infected, with or without their knowledge. As such, there may be a risk of exposure to the Coronavirus.

In order to reduce the risk of spreading COVID-19, we ask you to please answer number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

_____ _____ _____
Print Patient Name | Responsible Party Name (if applicable) | Date

Please add your initials next to the option "Yes" or "No" to indicate your answer to each of the questions.

1. **Within the last fourteen (14) days, have you or any person(s) in your household traveled to a country where community-based spread of COVID-19 is occurring, or to any other geographic region in the United States with sustained community transmission of COVID-19?**

   No _____ Yes* _____ *If yes, please indicate date(s) and location(s): _____

2. **Within the last fourteen (14) days, have you or any person(s) in your household had direct contact with a person confirmed or suspected to be positive with COVID-19?**

   No _____ Yes _____

3. **Within the last fourteen (14) days, have you or any person(s) in your household <u>been in close contact with</u> anyone who has experienced any of the following cold or flu-like symptoms: Fever or Chills, Cough, Shortness of Breath or Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Diarrhea?**

   No _____ Yes _____

4. **Within the last fourteen (14) days, have you or any person(s) in your household <u>experienced</u> any of the following cold or flu-like symptoms: Fever or Chills, Cough, Shortness of Breath or Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Diarrhea?**

   No _____ Yes _____

5. **Have you or any person(s) in your household been tested for COVID-19?**

   No _____ Yes** _____

   **If yes, please indicate:
   - Date(s) and result(s) of any tests _____
   - Date of symptom(s) onset _____
   - Date symptom(s) began improving _____
   - Last date you had a fever above 100.4 _____
   - Date when temperature fell below 100.4 _____
   - Last date of taking medications to control fever _____

6. **Have you or any person(s) in your household previously been asked to self-isolate or self-quarantine?**

   No _____ Yes*** _____

   ***If yes, please indicate date(s): _____

Patient
Temperature
_____°F or °C

_____ _____
Patient or Responsible Party Signature | Date

Last Updated: 7/29/2020