PATIENT ADVISORY and ACKNOWLEDGMENT
Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient,
You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines, to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of our knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

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

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

Question		
1. ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	YES_____	NO_____
2. DO YOU HAVE COVID-19? HAVE YOU BEEN IN CONTACT WITH ANYONE WHO HAS/HAD COVID-19? **IF SO, WHEN?**____________________	YES_____	NO_____
3. HAVE YOU HAD COVID? **IF SO, WHEN?**____________________	YES_____	NO_____
4. DO YOU HAVE ANY SHORTNESS OF BREATH, FEVER OR CHILLS?	YES_____	NO_____
5. DO YOU HAVE A DRY COUGH, RUNNY NOSE OR SORE THROAT??	YES_____	NO_____
6. DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	YES_____	NO_____
7. HAVE YOU EXPERIENCED HEADACHES, FATIGUE, WEAKNESS, NAUSEA OR DIARRHEA?	YES_____	NO_____
8. HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	YES_____	NO_____
9. WITHIN THE LAST 14 DAYS HAVE YOU TRAVELED TO ANY FOREIGN COUNTRY? **IF SO, WHERE?**____________________	YES_____	NO_____
10. WITHIN THE LAST 14 DAYS HAVE YOU TRAVELED WITHIN THE UNITED STATES? **IF SO, WHERE?**____________________	YES_____	NO_____

THANK YOU FOR YOUR COOPERATION AND UNDERSTANDING.

Question		
HAVE YOU BEEN FULLY VACCINATED AGAINST THE COVID-19 VIRUS? **IF SO, WHEN?**____________________	YES_____	NO_____

Patient Name/Responsible Party (Print)____________________________________

Signature of Patient/Responsible Party __________________________ Date __________