NAME:	PATIENT TEMPERATURE:

THANE B. ANDERSON DDS
Dentistry For Today's Family

COVID-19 Pandemic Dental Treatment and Acknowledgement of Risk Form

You have come to our office today for dental treatment. 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 their 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, other patients, and yourself, please be truthful and candid in your answers.

Please circle your response to each question and sign below.

ARE YOU AWAITING THE RESULTS OF A COVID 19 TEST?	YES NO
HAVE YOU HAD CONTACT WITH A CONFIRMED COVID-19 POSITIVE PATIENT?	YES NO
DO YOU HAVE A FEVER?	YES NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	YES NO
DO YOU HAVE A DRY COUGH?	YES NO
DO YOU HAVE A RUNNY NOSE?	YES NO
DO YOU HAVE A SORE THROAT?	YES NO
HAVE YOU EXPERIENCED HEADACHES, FATIQUE OR WEAKNESS?	YES NO
HAVE YOU LOST YOUR SENSE OF TASTE OR SMELL?	YES NO
IN THE LAST 14 DAYS, HAVE YOU TRAVELED OUT OF WI OR THE US??	YES NO

If you have traveled, where did you travel to_____

By signing I am confirming the information I have provided above is accurate. I acknowledge and understand the risks of contracting COVID-19 from outside this office or in this dental office and I accept those risks. I have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

_____ _____/_____/_____

PATIENT/RESPONSIBLE PARTY DATE