

NAME:

PATIENT

TEMPERATURE:



## 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 WITHIN THE LAST 3 WEEKS? YES NO

DO YOU HAVE A FEVER, COUGH OR SHORTNESS OF BREATH? YES NO

DO YOU HAVE A RUNNY NOSE OR SORE THROAT? YES NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE OR WEAKNESS? YES NO

HAVE YOU LOST YOUR SENSE OF TASTE OR SMELL? YES NO

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