FAMILY DENTISTS, P.A.

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 practicing recommended guidelines. 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.**

PATIENT/RESPONSIBLE PARTY _____ DATE _____
SIGNATURE: _____

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME? _____ YES NO

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? _____ 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

DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? _____ YES NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? _____ YES NO

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

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY? _____ YES NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY? _____ YES NO

IF SO, WHERE? _____

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