Patient Advisory and Screening Form

Dear Patient:

Thank you for coming to our office today for routine dental evaluation and/or treatment. 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 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.

____ ________________
Patient/Responsible Party Date

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

Are you currently awaiting the results of a COVID-19 test? ____**Yes** _____**No**

Do you have a fever? ____**Yes** _____**No**

Do you have 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? ____**Yes** _____**No**

If so, where? ____