

Patient Advisory and Acknowledgement **Receiving Dental Treatment During the SARS-COV-2 Pandemic**

Dear Patient/Parent,

You are presenting to our office for dental treatment. While our office complies with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the SARS-COVID-19 virus.

In order to reduce the risk of spreading SARS-COV-2, please answer the following screening questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

I understand there will be a \$15 per patient/\$30 max per family "COVID-19 PPE Safety fee" applied to each dental appointment

Parent/Guardian Name: _____

Date: _____

Parent/Guardian Signature: _____

For Office Use Only
Child's Temperature:
Parent's Temperature:

Child's Name: _____

Regarding the patient (your child):	No	Yes
Are you currently awaiting the results of a COVID-19 test?		
Are you in contact with any confirmed COVID-19 positive patients?		
Do you have a fever?		
Do you have any shortness of breath?		
Do you have a dry cough?		
Do you have a runny nose?		
Do you have a sore throat?		
Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?		
Have you experienced headaches, fatigue, or weakness?		
Have you lost your sense of taste and/or smell?		
Within the last 14 days, have you travelled to any regions affected by COVID-19?		If yes, where?