ADVANCED DENTISTRY

WITH A GENTLE TOUCH

Pre-Appointment Questionnaire

COVID-19 Pandemic Dental Treatment Consent Form

FULL NAME:

First Name _____ **Last Name** _____

Phone # ( ) _____ **Email** _____

Do you have a fever, or have you felt feverish recently? ☐ Yes ☐ No

Do you have a cough? ☐ Yes ☐ No

Are you having shortness of breath or any difficulty breathing? ☐ Yes ☐ No

Do you have chills or repeated shaking with chills? ☐ Yes ☐ No

Do you have any muscle pain? ☐ Yes ☐ No

Do you have any flu-like symptoms? ☐ Yes ☐ No

Do you have any recent onset of headache or sore throat? ☐ Yes ☐ No

Do you have any recent loss of taste or smell? ☐ Yes ☐ No

Have you experienced any recent GI upset or diarrhea? ☐ Yes ☐ No

Are you in contact with anyone who has been confirmed to be COVID-19 positive? ☐ Yes ☐ No

Have you traveled in the past 14 days to any regions affected by COVID-19? ☐ Yes ☐ No

Are you over the age of 65? ☐ Yes ☐ No

Do you have? ☐ Heart Disease ☐ Lung disease ☐ Kidney disease ☐ Diabetes ☐ Autoimmune disorder ☐ None of the above

OVER (Complete other side)→

COVID-19 Pandemic Dental Treatment Consent Form

Initials

I knowingly and willingly consent to having dental treatment completed during the COVID-19 pandemic.

_____

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. Given the current limits in the virus testing, it is impossible to determine who has it and who does not have COVID-19.

_____

Dental procedures create water spray (aerosols), which is one way the disease can be spread. The ultra-fine nature of the spray can linger in the air for several minutes to hours, which can transmit the COVID-19 virus.

_____

I understand that due to the frequency of visits of other dental patients, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.

_____

I understand that air travel significantly increases the risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days around anyone who has traveled by air, and this distance is not possible with dentistry.

_____

I confirm that I am not presenting any of the following symptoms of COVID-19:

- Fever
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat

_____

I verify that I have not traveled outside the United States during the past 14 days to countries that have been affected by COVID-19.

_____

I verify that I have not traveled within the United States by commercial airline, bus, or train within the past 14 days.

_____

Signature _____ Date _____/_____/_____

FOLLOW UP APPOINTMENT:

☐ I verify that there have been no changes to this questionnaire since my last dental appointment.

Signature _____ Date _____/_____/_____