Patient Advisory and Acknowledgment:
Receiving Dental Treatment During the COVID-19 Pandemic

Patient Name_____

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 the rules and regulations set forth by the Texas State Board of Dental Examiners and has implemented guidelines from the Centers for Disease Control and Prevention in an effort 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 are asking you a series of screening questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

Do you currently have, or in the last 72 hours had, a fever over 100.4 degrees? **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 had any loss of taste/smell? **Yes No**

Have you had any GI symptoms? Diarrhea? Nausea? **Yes No**

Are you currently awaiting the results of a Covid-19 test? **Yes No**

Have you been in contact with anyone that has tested positive, presumed positive, or under investigation for COVID-19 in the last 14 days? **Yes No**

Does anyone in your household currently have, or in the past 72 hours had, a fever over 100.4? **Yes No**

Within the last 14 days, have you traveled within, or outside, the United States? If so, where? **Yes** **No**

_____

Temperature recorded by office _____

Treatment: Approved ____ Denied ____

I authorize and give consent for the completion of planned dental care. By signing this form I acknowledge and accept the risk of exposure in the dental office to a communicable disease including, but not limited to, Covid-19. My signature means that I have read this form, understand the contents, and give my consent as stipulated above.

Printed name _____ Relationship to patient _____

Signature _____ Date _____