COVID-19 Patient Advisory and Screening:

Receiving Dental Treatment During the COVID-19 Pandemic

You will be presenting to the office today for treatment during the COVID-19 risk period. Please be advised to the following:

> 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 without their knowledge.
>
> While our office complies with the State Health Department and the Centers for Disease Control guidelines to prevent the spread of the COVID-19 virus.
>
> 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. It is impossible to determine who has it and who does not, without current testing.

I confirm that I have read the Notice above and understand and accept that there may be an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contact the COVID-19 virus from outside this office and unrelated to my visit here.

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. **Please Answer "Yes" or "No" to the following questions:**

Question		
Are you currently awaiting the results of a COVID-19 test? Or been in contact with someone who tested positive for COVID in the last 14 days?	______ **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 or sore throat?	______ **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 traveled outside of Florida?	______ **YES**	______ **NO**
Have you been in contact with anyone who has traveled to any countries or states?	______ **YES**	______ **NO**

IF SO, then where?______________________________

____ ______________

Patient Signature / Responsible Party Date

____

Print Name