

COVID-19 Pandemic Patient Disclosures & Informed Consent

Our office is committed to delivering necessary dental care to our patients in the safest manner possible at all times. It is our promise to you that we continue to follow all infection control & safety guidelines provided by the Department of Health, CDC, & OSHA to help prevent the spread of COVID-19. 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 our patients) could be infected, with or without their knowledge. We are taking every possible measure to prevent against individuals unknowingly bringing COVID into this office by asking the following screening questions, taking temperatures on all staff and patients, and using a pulse oximeter on all persons to screen for low oxygen saturation (often a silent sign of COVID). Despite taking all of these precautions, we are unable to make any guarantees. If you should develop any signs or symptoms of COVID-19 or a positive COVID-19 test in the 14-day period following your dental appointment, please contact this office to make us aware.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, and other medical conditions) can put you at a greater risk for contracting COVID-19. It is your decision if you would prefer to delay treatment at this time.

Do you have a fever?	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you tested positive for COVID-19?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you experiencing shortness of breath or difficulty breathing?	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have a dry cough?	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you been tested for COVID-19 and are awaiting results?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have a runny nose?	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you traveled outside of the US for any reason in the past 14 days?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you had a reduction in taste/smell?	<input type="checkbox"/> yes <input type="checkbox"/> no	Have you traveled outside of the state for any reason in the past 14 days? *	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have a sore throat?	<input type="checkbox"/> yes <input type="checkbox"/> no	* If you answered yes to out-of-state travel, please indicate state here: _____	
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache, muscle aches or fatigue?	<input type="checkbox"/> yes <input type="checkbox"/> no	Please record Temperature and SpO2 level below: Temperature: _____ SpO2: _____	
Even if you do not currently have any of the above symptoms, have you experienced any of these symptoms in the past 14 days?	<input type="checkbox"/> yes <input type="checkbox"/> no		

Guidance: If a patient has a temperature over 100.4 degrees, has an SpO2 under 90 (or under 93 with shortness of breath) or if patient provides positive responses to screening questionnaire, the patient is to be referred to his/her primary healthcare provider. The patient should not be seen for dental treatment.

Patient Name (Please Print): _____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____