**COVID-19 Pandemic Dental Consent and Health Questionnaire.** **Date: _____________**

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

❑ CONSENT TO TREATMENT ❑ I **DO NOT** CONSENT TO TREATMENT

***We need just a little more information.*** If you have been exposed to a communicable disease, you may spread the disease to the in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

- **Have you, your child, or others accompanying you to today's appointment or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease?*** ❑Yes. ❑No
- **Have you, your child, or others accompanying you to today's appointment or other recent acquaintances traveled outside the state within the past 14 days?*** ❑Yes. ❑No
- **Do you, your child, or others accompanying you to today's appointment or other recent acquaintances have:**
  - **A Fever? (defined as above 99.6 degrees)*** ❑Yes. ❑No
  - **A Cough?*** ❑Yes. ❑No
  - **Shortness of Breath and/or Trouble Breathing?*** ❑Yes. ❑No
  - **Persistent Pain, Pressure, or Tightness in the Chest?*** ❑Yes. ❑No
  - **A Loss of Taste or Smell?*** ❑Yes. ❑No

- ***I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's Dental appointment.***

Patients Signature: ____________________ Please Print Name: __________________

Parent/Guardian Name (If Applicable): ______________ Relationship: __________