Patient Advisory and Acknowledgement
COVID-19 Screening Form

Dear Patient:

Thank you for coming to our office today for a dental cleaning or treatment. Before your visit, we want to inform you of the following:

Our office complies with our State Health Department and Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, but we cannot guarantee you will not have any exposure to the virus.

As a precaution, we will be limiting the number of patients in the office at a time. If you would prefer to remain in your car until your appointment time, we will text you to let you know when we are ready to seat you. All patients will have their temperature taken when entering the office. We have also installed medical grade air purification systems to provide an extra layer of safety, and will be wearing face shields and surgical masks approved by the CDC. We have always used standard precautions and everything used during patient treatment is wrapped and sterilized using hospital grade sterilization techniques, or is for one use only and therefore disposable.

To our knowledge, our staff are symptom-free, and we are also taking their temperatures on a daily basis. They have not been exposed to the virus to the best of their knowledge. However, as I am sure you have heard on the news and the internet, since we are a public place of business 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 number of "screening" questions below. For the safety of our staff, other patients, and yourself, we need for you to please be truthful and candid in your answers.

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

DO YOU HAVE A FEVER, OR HAVE YOU HAD A FEVER WITHIN THE PAST ___ DAYS?	_____ 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
HAVE YOU HAD ANY DIARRHEA OR VOMITING?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO

If SO, WHERE? _____

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES? _____ YES _____ NO

IF SO, WHERE? _____

HAVE YOU TESTED POSITIVE FOR COVID-19? _____ YES _____ NO

IF SO, WHEN? _____

HAVE YOU COME IN CONTACT WITH SOMEONE WHO TESTED POSITIVE FOR COVID-19? _____YES _____ NO

IF SO, WHEN? _____

I have been given the opportunity to ask Dr. Desai/ Dr. Rahman and the staff of Lavista Park Family Dentistry questions regarding their Covid-19 treatment protocol, and I understand the risks involved in being treated today.

I give my permission and consent for Dr. Desai / Dr. Rahman to provide me with necessary dental treatment.

_____ _____

Patient/ Responsible Party Date

Name: _____

_____ _____

Witness Date

Name: _____