Patient Intake Form Regarding COVID-19

Patient Name: ____

Yes No Has your child or a family member had a fever or experienced fever within the past 14 days?

Yes No Has your child or anyone in the family experienced a recent onset of respiratory problems or fever, shortness of breath, cough, difficulty breathing or other flu-like symptoms like muscle aches, fatigue or within the past 14 days?

Yes No Has your child or anyone in your family come into contact with anyone with confirmed or presumptive (waiting on test results or asked to self-quarantine) COVID-19 infection within the past 14 days?

Yes No Has your child or anyone in your family recently participated in any gatherings, meetings or had close contact with many unacquainted people, or been in a group greater than the number recommended by the governor?

I, ______________________________________, knowingly and willingly consent to have my child receive dental treatment during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. It is impossible to determine who has it and who does not without a test.

Some dental procedures create a spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I understand that due to the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.

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Parent/Guardian Signature Date

*We are committed to continuing care for our patients. If you answered yes to any of the above questions, we may need to reschedule your appointment. We all look forward to a healthier future. We know we will be there soon by doing our part. Thank you for your understanding in these unprecedented times.