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COVID-19 PANDEMIC DENTAL TREATMENT SCREENING/CONSENT FORM

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19.

Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

Have you had a fever or felt feverish in the last 14 days?	Yes_____	No_____
Have you had shortness of breath or any difficulty breathing?	Yes_____	No_____
Do you have a cough?	Yes_____	No_____
Any other flu-like symptoms, such as GI upset, headache or fatigue?	Yes_____	No_____
Have you experienced recent loss of taste or smell?	Yes_____	No_____
Have you (or anyone in your household) been in contact with confirmed covid-19 positive patients?	Yes_____	No_____
Do you have any heart disease, lung disease, kidney disease? diabetes, or blood/clotting disease?	Yes_____	No_____
Have you traveled on a plane or public transportation? in the last 14 days?	Yes_____	No_____
Have you been practicing all current CDC guidelines? with respect to "social distancing?"	Yes_____	No_____

I hereby acknowledge and understand that there may be an increased risk that COVID-19 may be transmitted in any place of public accommodation, which includes our dental office. I have been informed by Advanced Periodontics & Implantology PLC, of their desire to protect their patients, staff and the community at large. **WE ARE TAKING EVERY PRECAUTION NECESSARY TO LIMIT THE EXPOSURE OF ANY VIRUS WITHIN OUR OFFICE.**
By signing this document, I acknowledge that the answers I have provided to my provider are true and accurate.

_____ _____

Signature Date

_____ _____

Print Name Witness