HERITAGE DENTAL

COVID-19 Patient Screening FormDate _____

Patient Name	**Pt Temp**
Do you have a pre-existing condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	YES/NO
Are you experiencing shortness of breath or trouble breathing?	YES/NO
Are you experiencing a sore throat or coughing?	YES/NO
Are you experiencing repeated shaking/chills or muscle aches?	YES/NO
Are you experiencing gastrointestinal changes?	YES/NO
Have you noticed a loss of smell or taste?	YES/NO
Have you had contact with a known/suspected COVID-19 + person?	YES/NO
Have you traveled in the last 14 days?	YES/NO
If yes to the question above, please specify:	

Patient Supplemental Informed Consent: Dental Treatment in the Era of COVID-19

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 continue to follow state and federal regulations as well as recommended universal personal protective equipment (PPE) and disinfection protocols to limit transmission of all diseases in our office.

Despite our careful attention to sterilization, disinfection and the 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 exposed at your gym, grocery store or favorite restaurant. Nationwide social distancing has reduced the transmission of the coronavirus. Although we have taken measures to enable 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, dental healthcare team members and sometimes other patients at all times. Thank you for your patience and understanding.

Although exposure is unlikely, do you accept the risk and consent to treatment? YES/NO

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Patient/Parent's Signature