INFECTIOUS DISEASE SCREENING AND DISCLOSURE/CONSENT

1. Have you OR anyone you are in close contact with been diagnosed or is being monitored for COVID-19 in the last 30 days? ☐ No ☐ Yes

2. Are you OR anyone you are in close contact with currently experiencing any of the following symptoms?

Cough	☐ No	☐ Yes
Sore Throat	☐ No	☐ Yes
Fever (Greater than 38.0 C or 100.4 F)	☐ No	☐ Yes
Muscle pain	☐ No	☐ Yes
Weakness	☐ No	☐ Yes
Diarrhea/Vomiting/Abdominal Pain	☐ No	☐ Yes
Difficulty breathing/Shortness of breath	☐ No	☐ Yes

Current studies indicate that some dental procedures create aerosolized particles (similar to a sneeze) of the virus that causes COVID-19, which can linger in the air for minutes to sometimes hours, which can result in transmission of COVID-19 (Coronavirus) from an infected person. I fully understand that proceeding with the treatment today may increase my exposure and therefore my risk of contracting community acquired COVID-19 (Coronavirus) infection.

I am consenting to treatment with full understanding and disclosure of such risks and alternatives, and all my questions were answered to my satisfaction.

______________________________ ______________________________

Patient Name Signature

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Date