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General and Cosmetic Dentistry
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Health Questionnaire & Consent- Dental Treatment in the Era of COVID-19

Patient Name: _____

We will be taking everyone's temperature upon entering our office

Do you, any family member, others accompanying you to today's appointment or anyone you have recently been in contact with have any of the following symptoms?

Fever (defined as above 100.4 degrees)? **Yes_____** **No_____**

Cough? **Yes_____** **No_____**

Shortness of breath and/or trouble breathing? **Yes_____** **No_____**

Persistent pain, pressure or tightness in the chest? **Yes_____** **No_____**

Have you or an immediate family member been outside of the country within the last 21 days? **Yes_____** **No_____**

Have you, any family member, others accompanying you to today's appointment or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any communicable diseases? **Yes_____** **No_____**

If yes, please provide approximate dates of illness_____

- I understand that if the answer to any of these questions is yes or if I have a fever above 100.4, I may be asked to reschedule today's dental appointment to a later date.
- I have adequate information regarding the COVID-19 virus and pandemic and fully comprehend the associated risk to my safety proceeding with dental treatment.

_____ _____

Patient/Parent's Signature Date (day of appointment)