Patient Advisory and Acknowledgment

Receiving Dental Treatment during COVID-19 Pandemic

PLEASE ANSWER "YES" OR "NO" WITH INITIALS, TO THE FOLLOWING QUESTIONS:

	YES	NO
Are you currently awaiting the results of a COVID-19 test?		
Do you have a fever?		
Do you have any shortness of breath?		
Do you have a dry cough?		
Do you have a runny nose?		
Do you have a sore throat?		
Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?		
Have you experienced headaches, fatigue, or weakness?		
Have you lost your sense of taste and/or smell?		
Within the last 14 days, have you travelled to a foreign country?		
Within the last 14 days. Have you travelled within the United States? If so, where? ____		

Our practice complies with State Health Department and the CDC infection control guidelines to prevent the spread of the COVID-19 virus; however, we cannot make any guarantees. Our team is screened daily and, to the best of their knowledge have not been exposed to the virus. We are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge. I hereby knowingly and willingly consent to have dental treatment completed at this time. I will hold harmless and indemnify, the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions, in exchange for dental treatment during the events of COVID-19 National Emergency. I make this decision of my own free will relying upon my knowledge and judgement of any injury I may have sustained or possible transmission of COVID-19 during treatment and my decision to release has not been affected by any false statements or representation pertaining to those injuries. I have read carefully this release and understand its contents, and I am signing it of my own free act.

Patient Name: ____

Patient Signature: ____

Date: __________________________