FAMILY SMILES dental care

COVID-19 Patient Screening and Consent

Temperature at Check-in:	
Do you have a fever or have you felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No
Are you having shortless of breath or other difficulties breathing?	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☐ Yes ☐ No
Are you in contact with any confirmed COVID-19 positive patients?	☐ Yes ☐ No
Is your age over 60?	☐ Yes ☐ No
Do you have diabetes, any autoimmune disorders, or disease of the heart, lungs or kidneys?	☐ Yes ☐ No
Have you traveled in the past 14 days to any regions affected by COVID-19?	☐ Yes ☐ No

I agree to contact the office and my primary care physician if I develop any COVID-19 symptoms within the next 14 days.

I understand the office is required to use additional personal protective equipment and take extra precautions to minimize risk of further transmission of the disease. While the office has made the decision to cover the majority of the additional cost associated with COVID-19 guidelines, I will be charged a minimal per visit fee of $15.00 to help cover the additional expense. My insurance carrier may or may not have a benefit that can be applied to this charge.

I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____