Patient Advisory and Acknowledgement

Receiving Medical/Dental Treatment during the COVID-19 Pandemic

Dear Patient,

You have presented to the office today for dental treatment. While our office complies with the State Health Department and the Centers for Disease Control and Prevention, infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff is symptom-free and to the best of our knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) may be infected (with or without their or our knowledge). Be advised, all exam rooms are sanitized with CDC approved cleaning solutions between patients. All patients, providers and staff should wear masks during the visit. Frequent hand washing and glove changes are practiced by our providers. We will also make every effort to minimize your time spent in our reception area. Note – if you wish you may wait for your appointment time in your vehicle.

In order to reduce the risk of spreading COVID-19, we ask that you fill out the screening form below. For the safety of our staff, other patients and yourself, please be truthful and candid in your answers. If you are not feeling well today, we may ask you to reschedule your appointment without penalty.

Please answer 'YES' or "NO' with your initials to the following questions:

Do you have a fever?   _____ Yes   _____ No

Do you have any shortness of breath?   _____ Yes   _____ No

Do you have a dry cough?   _____Yes   _____ No

Do you have a sore throat?   _____ Yes   _____ No

Do you have chills, a headache, or muscle pain?   _____ Yes   _____ No

Do you have any flu-like symptoms?   _____ Yes   _____ No

Have you experienced a recent loss of taste or smell?   _____ Yes   _____ No

Have you been diagnosed with COVID-19, or have you been exposed to someone with COVID-19,

   or someone with the symptoms of COVID-19 in the past 2 weeks   _____ Yes   _____ No

Within the last 2 weeks, have you traveled to any foreign country or outside the Washinton DC

   Metropolitan area? If so, where? _____   _____ Yes   _____ No

_____   _____

Patient/Responsible party   Date