

COVID-19 Patient Notice and Acknowledgement Form

Patient Name: _____ Temperature _____ F (Office Use)

Do you currently have or had any of the following symptoms of COVID-19 in the last 14 days:

- Yes _____ No _____ Fever or chills
Yes _____ No _____ Cough
Yes _____ No _____ Shortness of breath or difficulty breathing
Yes _____ No _____ Fatigue
Yes _____ No _____ Muscle or body aches
Yes _____ No _____ Headache
Yes _____ No _____ New loss of taste or smell
Yes _____ No _____ Sore throat
Yes _____ No _____ Congestion or runny nose
Yes _____ No _____ Nausea or vomiting
Yes _____ No _____ Diarrhea

(This list is not all possible symptoms. CDC will continue to update the list as we learn more about COVID-19.)

Have you traveled more than 100 miles within the last 14 days? Yes _____ No _____

Have you come in contact with anyone with the COVID-19 in the last 14 days? Yes _____ No _____

Have you been tested for COVID-19 in the last 14 days? Yes _____ No _____

If yes, what is the test result? Negative _____ Positive _____

_____ Initials I understand that due to the frequency of other patients being seen and the nature of the COVID-19 virus being an airborne virus, there is an increased level of risk by being in a dental office. I understand the CDC recommends social distancing of six feet and this is not possible in dentistry. I have been informed of the preventive steps and safety protocols that are in place to protect myself, dental employees and the doctor while being seen for treatment.

_____ Initials I am comfortable with the information that has been provided. I understand that I have the option of delaying treatment and I am knowingly and willingly electing to proceed with treatment at this time.

_____ Initials I agree to notify the dental practice if within 2 days I developed COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 2 days.

Patient or Guardian Signature: _____ Date: _____