SN FAMILY DENTAL CENTER

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COVID-19 Patient Prescreening & Consent Form

Date: _____

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Phone: _____
Home Mobile Work Ext

Best time to call: _____ E-Mail: _____

Do you have fever or have you felt hot or feverish recently (14-21 days)? ◯ Yes ◯ No

Are you having shortness 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 people that have been confirmed COVID-19 positive?

Patient's who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment. ◯ Yes ◯ No

Are you over 60 years old? ◯ Yes ◯ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? ◯ Yes ◯ No

Have you traveled in the past 14 days to any regions affected by COVID-19? ◯ Yes ◯ No

Travel History within United States? _____

International Travel History? _____

Did you get test done for Covid-19? ◯ Yes ◯ No

If yes when was the test done date? _____

Are you still Positive or Negative? ◯ Yes ◯ No ◯ Not tested

If yes, when did you find out date? _____

If positive, were you any of the following?

◯ Asymptomatic ◯ Symptomatic ◯ Hospitalized ◯ Ventilator

When did you become COVID-19 Negative? _____

First tested date for COVID-19 Negative? _____
(Please bring the paperwork with you)

Second tested date for COVID-19 Negative? _____
(Please bring the paperwork with you)

COVID-19 Antibodies Testing done? ◯ Yes ◯ No

If yes when was the test done date? _____

Antibody Present or Not Present date? _____

Did you attended any protest rally in last two weeks? ◯ Yes ◯ No

Please check the following regarding recent gatherings.

☐ Parties ☐ Backyard \ BBQ Parties ☐ Family Get-togethers ☐ Religious Events ☐ Beach Visit

☐ Indoor Dining ☐ Hair Salon ☐ Nail Spa ☐ Physical Therapy ☐ Gym ☐ None

Please give details below such as date, number of people and any other important information. This information is to help us keep our patients safe as well as our staff.

NOTE:

_____

PATIENT CONSENT

SUPPLEMENTAL INFORMED CONSENT:

Dental Treatment in the Era of COVID-19 Patient

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection protective equipment (PPE) and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing Between the patient, dental healthcare team members and sometimes other patients at all times.

Although the risk to exposure, do you accept the risk and accept the treatment? ◯ Yes ◯ No

_____ _____

Signature Response Date