Screening Questionnaire and Dental Treatment Consent

- **COVID-19 Pandemic Recovery Phase COVID-19**
- **Screening Questionnaires and Dental Treatment Consent Form**

- Patient First Name *
- Patient Last Name *
- Please Read and Acknowledge by checking the box *

  ☐ I knowingly and willingly consent to have dental treatment completed during the recovery phase of COVID-19 Pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.
- Please Read and Acknowledge by checking the box *

  ☐ I understand, even with all precautionary measures based on CDC and ADA guidelines; there is a potential risk of contracting the virus simply by being in the dental office.
- Do you or have you had any flu-like symptoms in the last 14 days, such as cough or shortness of breath? *

  ○ No ○ Yes
- Do you have at least two of the symptoms below? (Please check the symptoms you have):

  ☐ Fever ☐ Chills ☐ Repeated shaking ☐ Fatigue ☐ Muscle aches ☐ Vomitting ☐ Headache ☐ Sore Throat ☐ New loss of taste or smell ☐ Malaise ☐ Nausea ☐ Diarrhea
- Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? *

  ○ No ○ Yes
- Are you awaiting results of a lab test for COVID-19 ? *

  ○ No ○ Yes
- Have you tested positive for COVID-19? *

  ○ No ○ Yes
- Have you re-tested negative since testing positive?

  ○ No ○ Yes
- Have you or a family member previously been asked to self-isolate or self-quarantine in the past 14 days? *

  ○ No ○ Yes
- Have you had close contact to an individual diagnosed with COVID-19 infection in the past 14 days? *

No Yes

- Please Read and Acknowledge by checking the box *

  I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry.
- Please Read and Acknowledge by checking the box *

  I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19.
- Please Read and Acknowledge by checking the box *

  I acknowledge the Governor of Texas issued Executive Order (GA-20) stating the mandated 14-day quarantine for travelers from the following areas remain in place: California; Connecticut; New York; New Jersey; Washington; Atlanta, Georgia; Chicago, Illinois; Detroit, Michigan, and Miami, Florida. I verify that I have not traveled within the mandated states (within the United States by commercial airline, bus or train within the past 14 days.
- Date * /MM /DD YYYY
- Draw your signature into the box below. *
  Clear
- Relationship to the patient *
- Name if not the patient *