COVID-19 PANDEMIC - PATIENT SCREENING FORM

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

PATIENT NAME: _____ DATE: _____

Have you tested positive for COVID-19?	YES OR NO
Have you been tested for COVID-19 and are awaiting results?	YES OR NO
Do you have a fever or above normal temperature?	YES OR NO
Have you experienced shortness of breath or had trouble breathing?	YES OR NO
Do you have a dry cough and/or sore throat?	YES OR NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES OR NO
Have you recently lost or had a reduction in your sense of smell or taste?	YES OR NO
Have you been in contact with someone who has tested positive for COVID-19?	YES OR NO
Have you traveled within the United States by air, bus or train within the past 14 days?	YES OR NO
Is your/their age over 60?	YES OR NO
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto- immune disorders?	YES OR NO

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

X _____

Patient Signature

CHARLES ASHLEY MANN, DDS AND ASSOCIATES
Family and Cosmetic Dentistry

CHARLES ASHLEY MANN, DDS
AND ASSOCIATES
Family and Cosmetic Dentistry

"You are receiving dental care during the events of a COVID-19 National Emergency. Please be advised that there may be risks in being in the proximity of dentists, patients and staff. We are taking precautions to limit the spread of disease, yet there is still a possibility of transmission."

The patient, _____, will hold harmless and indemnify, the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions regarding Covid-19 infection, in exchange for dental treatment during the events of COVID-19 National Emergency for 30 days from today.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date