Gilrain and Brooks, D.D.S., P.C.
Patient Advisory and Acknowledgment
Receiving Dental Treatment During the COVID-19 Pandemic

PATIENT NAME (PRINT)_____

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

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 are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

I agree to notify the dental practice if within 48 hours I become ill with COVID-19 symptoms or test positive for COVID-19. I understand that I have the possibility to delay my treatment, and I have elected to have the procedure at this time.

_____ _____ _____
SIGNATURE DATE TEMPERATURE

HAVE YOU BEEN DIAGNOSED POSITIVE FOR COVID-19 VIRUS AT ANY TIME? **_____YES _____NO**

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? **_____YES _____NO**

HAVE YOU BEEN EXPOSED TO ANYONE WHO HAS BEEN DIAGNOSED WITH COVID-19 IN THE PAST 21 DAYS? **_____YES _____NO**

DO YOU HAVE A FEVER? **_____YES _____NO**

DO YOU HAVE SHORTNESS OF BREATH? **_____YES _____NO**

DO YOU HAVE A DRY COUGH? **_____YES _____NO**

DO YOU HAVE A SORE THROAT? **_____YES _____NO**

DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? **_____YES _____NO**

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? **_____YES _____NO**

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? **_____YES _____NO**

HAVE YOU VISITED OR RECEIVED TREATMENT IN A HOSPITAL, LONG-TERM CARE FACILITY, OR OTHER HEALTH CARE FACILITY IN THE PAST 30 DAYS? **_____YES _____NO**

ARE YOU OR ANYONE IN YOUR HOUSEHOLD A HEALTH CARE PROVIDER OR EMERGENCY RESPONDER? **_____YES _____NO**

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY? **_____YES _____NO**
IF SO, WHERE?_____