Wellness Screening and Treatment Consent

Thank you to our dental family and friends for your support and patience as out office closed to comply with government directives during the peak of the COVID-19 pandemic. We look forward to resuming care in the safest possible way.

Please respond to the questions of this wellness screening:

Date:____________________

Your name:______________________________

Patient's name, if different:_______________________________

1. Have you traveled within the past 14 days? Y/N

2. Have you or anyone in your household been in contact with someone who has been diagnosed or assumed to be positive for COVID-19? Y/N

In the past 14 days have you or anyone in your household had:

3. Fever over 99.6 degrees: Y/N

4. Dry cough: Y/N

5. Shortness of breath: Y/N

6. Loss of taste or smell: Y/N

7. Sore throat: Y/N

8. Travel by airplane or cruise ship: Y/N

Has the patient, a family member, or any known close contact had either the following occur:

9. Diagnosis of COVID-19 infection or any other communicable disease: Y/N

10. Waiting on results of test for COVID-19 infection: Y/N

11. If a patient, family member, or close contact has been diagnosed with COVID-19 infection, when did that occur? _________________

Treatment Consent:

Please be assured that our office has always met or exceeded the requirements set forth for sterilization and infection control from the Centers for Disease Control and Prevention and OSHA, and will continue to do so. However, it is possible to contract COVID-19 infection or any other communicable disease in any public space. Our office will provide for socially distant appointment scheduling. We have also added a number of new technologies and techniques to enhance our level of safety. However, due to the nature of dental treatment, social distance is not possible between patient and staff. Exposure to communicable disease is unlikely but possible. Your signature below indicates that the risks involved are accepted and that consent is given for treatment at Mt. Graham Dental.

Signature:____

Date:____________________