Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

CARTHAGE DENTAL ASSOCIATES

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INFORMED CONSENT FOR DENTAL TREATMENT DURING COVID – 19 PANDEMIC

I,_____, knowingly and willingly consent to have dental treatment completed during the 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 may be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing. Dental procedures create water spray(aerosols), which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, and this can transmit the COVID-19 virus.____(Initial)

I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, I have an elevated risk of contracting the virus simply by being in the dental office.____(Initial)

I confirm I am not presenting with currently nor have I presented in the past 14 days with fever, shortness of breath, dry cough, runny nose, sore throat, or loss of taste or smell.____(Initial)

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 6ft for a period of 14 days to anyone who has traveled.____(Initial)

I verify that I have not traveled outside the United States in the past 14 days to an area that has been affected by COVID-19.____(Initial)

I verify that I have not traveled domestically within the United States outside the surrounding area by commercial airline, bus, or train within the past 14 days.____(Initial)

Since the nature of our work deals directly with oral membranes and fluids, we must respond in an appropriate and timely manner in order to protect our patients and our staff members. We have always adhered to Standard Precautions in sterilization and disinfection and we will continue to take extra steps to advance our sterilization practices in our office.

Thank you for your cooperation in this matter.

Signature_____ Date_____ Witness_____

Temp_____