**Patient Advisory and Acknowledgement**

Dear Patient,

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 New Jersey Health Department and the CDC 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 without their knowledge.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(print), 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 still be highly contagious.

In order to reduce the risk of spreading the Covid-19, we have asked you a number of screening questions below.

**Please be truthful and candid when answering the questions below with your Initials.**

Have you been diagnosed positive for the Covid-19 Virus at any time? Yes \_\_\_\_\_No\_\_\_\_\_

Are you currently awaiting the results of a Covid-19 test? Yes \_\_\_\_\_No\_\_\_\_\_

Do you have a fever? Yes \_\_\_\_\_No\_\_\_\_\_

Do you have any shortness of breath? Yes \_\_\_\_\_No\_\_\_\_\_

Do you have a dry cough? Yes \_\_\_\_\_No\_\_\_\_\_

Do you have sneezing, watery eyes, and/ or sinus pain/ pressure that is unusual Yes \_\_\_\_\_No\_\_\_\_\_

And not related to seasonal allergies?

Have you experienced headaches, fatigue, or weakness Yes \_\_\_\_\_No\_\_\_\_\_

Recent loss of Taste or Smell Yes \_\_\_\_\_No\_\_\_\_\_

Within the last 14 days, have you traveled to any foreign country? Yes \_\_\_\_\_No\_\_\_\_\_

Within the last 14 days, have you travelled within the United Stated or Yes\_\_\_\_\_No\_\_\_\_\_

to any foreign country?

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will notify Riverside Dental Health if my status changes and I do contract the Covid-19 virus.**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_