Roselle Park Dental & Implants Patient Covid-19 Screening & Consent Form

Tec. Name & Date: **Pt Temp:** **Guardian/Name:**

Please circle one of the following:

Do you have a fever or felt hot/feverish Flu like symptoms recently in the past (10-14 days)? **YES / NO**

Are you having shortness of breath or other difficulties breathing? **YES / NO**

Do you have cough or sore throat? **YES / NO**

Have you experienced recent loss of taste or smell? **YES / NO**

Have you been in contact with any person(s) confirmed with COVID-19? **YES / NO**

**Patients who are well but who have a sick family member at home with COVID -19 should consider postponing treatment*

Have you traveled in the past 14 days to any regions affected by COVID-19? **YES / NO**

Have you been tested for COVID-19 within the last 14-28 days? **YES/ NO**

*** If your answer was yes, please provide date of occurrence and why you were tested.*

Date of test: ______________

For: work/medical? For other please explain: ____

Have you been vaccinated for COVID-19? **YES/NO**

I, __________________________knowingly and willingly attest that all my statements are true that I have provided to the office today and consent to having dental treatment completed during the Covid-19 pandemic. I understand COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not give the current limits in virus testing. I understand that dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus. *I am aware of the CDC & ADA guidelines on dental treatment and have not and am not presenting or experienced any for the symptoms of COVID listed above. I understand significantly increases my risk of contracting and transmitting the COVID -19 virus and that the CDC recommends social distancing of at least 6 feet and this is not possible with dentistry. I agree and confirm I am seeking dental treatment for a condition that meets these criteria of emergency, elective and or preventive care in my dental treatment today.

Signature: ____ Date: ___________