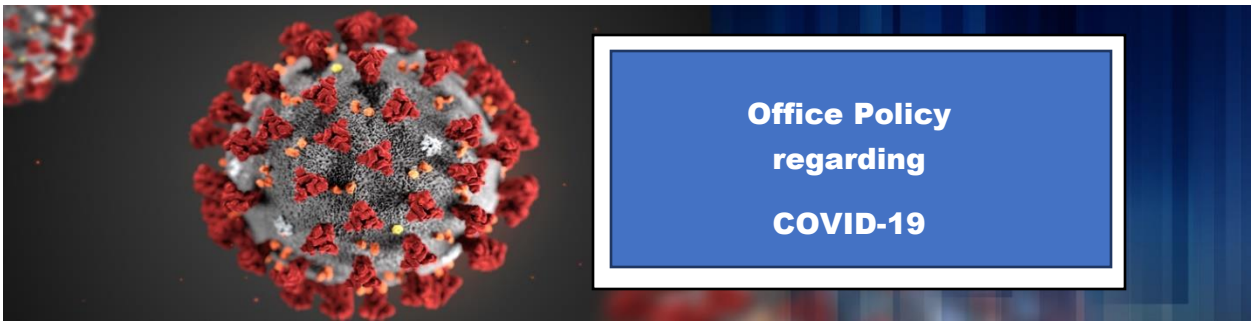

Please **DO NOT ENTER** If you have tested **POSITIVE**, **Waiting** for the test, or in **CONTACT** with patient with **Covid-19**

1. Upon your arrival to our office, We kindly ask that you to use the **HAND SANITIZER** we have provided.
2. Please **DISINFECT YOUR HANDS** prior to using any pens to fill out any documents we may need from you.
3. If using the restroom or existing and reentering our office , we ask that you use the **HAND SANITIZER** provided upon reentry.
4. In order to practice proper **SOCIAL DISTANCING**,We will be refraining from engaging unnecessary close contact, including handshaking, as a means of decreasing possible transmission of theCovid-19.
5. Due to current situation, **SOCIAL DISTANCING** and **SPACE LIMITATION**, **FAMILY MEMBERS** are **NOT** allowed in the office (**waiting area and/ operatory rooms**). We apologize for any inconvenience

COVID-19 Pandemic Dental Treatment Consent Form

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 still 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, which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

_____ - I understand that due to the frequency of visits of other dental patients, the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.

_____ - I have been made aware of the CDC, ADA, GDA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth and issues that may cause anything listed above within the next 3-6 months.

_____ - I confirm I am seeking for my dental treatment during the COVID-19 pandemic.

_____ - I confirm that I am **NOT** presenting any of the following symptoms of COVID-19 listed below.

NOTE:If you, family member or any person you in contact with tested positive or waiting for the test we will need NAGATIVE confirmation result in order to serve you.

By signing, you understand and agree to follow the above policies .We thank you for your participation and understanding in following these policies.

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 tested **positive**, in contact with any confirmed COVID-19 positive patients, or in-process for getting result of the test? *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

There will be an additional $10 cost due to the expense of extra PPE and safety equipment

Print Name: _____Signature: _____Date: _____

By signing, you understand and agree to follow the above policies .We thank you for your participation and understanding in following these policies.