CORONAVIRUS/COVID-19 PATIENT SAFETY QUESTIONNAIRE

In order to protect you, the doctor and staff, please **remain in your car**. We will call you when we are ready to bring you into the office. Please **leave your mask on** until asked to remove it. Please complete the following questions:

Name: ____ Date: ______________________

1. Have you traveled outside the United States or any regions affected by COVID-19 (as relevant to your region) in the past 21 days?

   ________ Yes ________ No

2. Have you maintained recommended social distancing for the past 2 weeks?

   ________ Yes ________ No

3. Do you have or have you had a fever or feel hot/feverish in the past 14-21 days?

   ________ Yes ________ No

4. Have you developed a cough, shortness of breath or other difficulties breathing in the past 4 weeks?

   ________ Yes ________ No

5. Have you experienced loss of sense of taste or smell in the past 4 weeks?

   ________ Yes ________ No

6. If employed, have you continued to go to your place of employment outside of your home?

   ________ Yes ________ No

7. Have you been in contact with anyone who has tested positive for coronavirus in the past 2 weeks?

   ________ Yes ________ No

8. Any other flu-like symptoms, such as gastrointestinal upset, headaches or fatigue?

   ________ Yes ________ No

Thank you for your cooperation and understanding during the coronavirus pandemic. We respect your concerns and understand your need to be seen for diagnosis and treatment.

Signature _________________

Informed Consent for Oral and Maxillofacial Health Care and Treatment –COVID 19

You have elected to receive oral and maxillofacial health care during COVID 19 pandemic on the grounds that you feel the need for the diagnosis, care and treatment is urgent or necessary. In addition to the standard risks associated with any oral and maxillofacial health care, please be advised that there may be heightened risks of infection with the virus arising from being in close contact with doctor, patients, or staff.

By signing below, you indicate that you wish to proceed with the diagnosis, care and treatment today and during COVID 19 pandemic and that:

1. You have discussed with your provider the risks vs. the benefits of proceeding at this time with the visit, rather than rescheduling to a time when the risk of infection from the virus may be substantially lower.

2. You understand that while the practice has taken precautions to limit the spread of the virus, there is still a possibility of transmission that may arise from your receipt of the diagnosis, care and treatment.

3. By following the guidelines from CDC, ADA, CDA, OSHA, CDPH, I will notify this office within two weeks of today's and any future visits if I test positive for COVID-19.

4. You have had an opportunity to consider whether you or any member of your household is at high risk of serious consequences should you become infected with the virus. See https://www.cdc.gov/coronoviurs/2019-ncov/specific-grounds/high-risk-complications.html

Patient Name: ____

Patient Signature: _____________________________________

If patient under 18:

Patient Name ____

Patient/guardian Signature: ______________________________

Date: ____

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