Patient Screening Form

ADA®

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.

Evergreen Valley Dental Office

Consent for Treatment During COVID-19 Pandemic

As you aware, healthcare offices are experiencing unprecedented changes and demand associated with the COVID-19 pandemic. Evergreen Valley Dental Office has implemented a variety of safety measures in an effort to protect its patients and employees. These measures include, but are not limited to, strict adherence to rules and guidelines implemented by the Centers for Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA), in addition to various best practices related to personal protective equipment and exposure control.

However, despite these best efforts, nothing can eliminate the risk of exposure to COVID-19 entirely. By signing this consent, you understand this risk exists and shall hold the dental practice where you receive treatment harmless from any COVID-19-related allegations. You further agree, taking into consideration this risk, to proceed with your prescribed dental procedure(s).

Patient Name(Printed): _____

Patient Signature: _____

Date: _____