GREGORY WRIGHT, DDS, PA

COVID-19 PANDEMIC – PATIENT DISCLOSURES AND CONSENT

Patient Name:_____ Guardian/Parent Name_____

This patient disclosure form seeks information from you that we must consider before making decisions in the circumstance of the COVID-19 virus.

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 contagious. Although it is possible to transmit viruses, I understand that strict infection control has ALWAYS been a top priority for this office. I understand that this office's infection control processes are meant for my safety and comfort and that this office goes beyond the infection control recommendations made by the American Dental Association (ADA), the U.S. Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA). All of our employees are screened daily and wear the appropriate personal protection equipment. Also, our employees and their families have not contracted the virus to date.

It is important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus. If you have been exposed or could potentially be a carrier, please stay home and call us to reschedule your appointment.

	YES	NO
Do you have a temperature 100.4 or greater?	◯	◯
Have you experienced shortness of breath or had trouble breathing?	◯	◯
Do you have a dry cough?	◯	◯
Have you recently had a loss or reduction in taste or smell?	◯	◯
Do you have a sore throat?	◯	◯
Have you been in contact with someone who has tested positive for COVID-19?	◯	◯
Have you tested positive for COVID-19?	◯	◯
Have you been tested for COVID-19 and are awaiting results?	◯	◯
Have you traveled outside the United States by air or cruise ship in the past 14 days?	◯	◯
Have you traveled within the United States by air, bus or train within the past 14 days?	◯	◯

_____(Initial) I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has traveled by air.

_____(Initial) I understand that I will contact the office (and my Primary Care Physician) if I develop any COVID-19 symptoms within the next 14 days.

Please record your temperature at home below.

Temperature at home: _____ Date: ____/____/_____

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any contributing conditions in my health history.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ Date: _____/_____/_____
Signature

OFFICE USE ONLY
Temperature at time of appointment: _____ Date: _____/_____/_____

_____
Witness