Patient Screening and Consent form for COVID-19

Patient Name: _____

This patient disclosure form seeks information that Pediatric Dental Specialists must consider before making treatment decisions for your child in the circumstance of the COVID-19 virus. I understand the following risks of receiving dental care during this time:

- The COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious.
- Due to the frequency of visits of other dental patients, the characteristics of the virus and of dental procedures, I understand I have an elevated risk of contracting the virus simply by being in a dental office.
- A weakened or compromised immune system can put you at greater risk for contracting COVID-19. I have disclosed all information regarding my health history to my provider.
- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6'. I understand this is not possible while performing dentistry.
- I understand the risk and willingly consent to my child receiving dental care during the COVID-19 Pandemic.

There are several modes of transmission of COVID-19 which could be present in a dental office. Pediatric Dental Specialists is following the ADA and CDC guidelines to minimize the risk of transmission. It is also important that you disclose to our 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.

	Pre-Appointment
Staff Initials:	**Date:**
Do you have fever, or have you felt hot or feverish recently (14-21 days)?	☐ YES ☐ NO
Are you having shortness of breath or other difficulties breathing, cough, or experiencing any loss of taste or smell?	☐ YES ☐ NO
Are you experiencing any flu-like symptoms such as gastrointestinal upset, headache, or fatigue?	☐ YES ☐ NO
Have you been in contact with anyone who has been confirmed positive with COVID-19? Or are you awaiting COVID test results? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ YES ☐ NO
Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorder?	☐ YES ☐ NO
Have you traveled out of the country in the last 14 days?	☐ YES ☐ NO
Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment and may end in needing to reschedule my treatment.	

By signing this document, I acknowledge that I have disclosed to my provider all conditions of my health history, the answers I have provided above are true and accurate at the time of my child's visit. There have been no changes to my child's condition since the pre-appointment phone call. I knowingly understand the risk and consent to my child receiving dental care.

_____ _____

Signature Date

(updated 6-9-2020)