

COVID-19 Patient Survey and Consent Form – Cornerstone Dental

The Covid-19 virus has a long incubation period during which carriers of the virus may not show symptoms and yet be highly contagious. There are also asymptomatic carriers that may never develop noticeable or significant symptoms. Therefore, it is impossible to determine who has the virus and who does not, given the current limitations of viral testing.

Therefore, to better ensure the safety of all our patients and staff, we are asking that you complete the following survey.

We are also asking that you follow social distancing guidelines while in the waiting room and reception/hallway areas of our office. This includes the wearing of face coverings. You are asked to bring your own, because there is still a significant shortage of these for professional use. Please put your mask on before coming into the office and wear it until you are in a treatment room; a member of our staff will tell you when it is appropriate to remove it. If you come into the office without a face covering, you will be supplied with a new unused disposable face mask while in the waiting room, but there will be a charge of \$2.00. Patients are being scheduled further apart, but if you should find yourself in the reception/checkout areas with another patient, please observe the social distancing guideline of remaining at least six (6) feet apart. We also require scanning for a body temperature reading prior to your dental treatment. The same survey and practices are required of all staff members on a daily basis.

I, _____, understand and agree to abide by the above practices and complete the following survey prior to receiving treatment at Cornerstone Dental during the Covid-19 pandemic.

Signed _____ Date _____

SURVEY

Have you had a fever or felt feverish in the last 14 days? YES NO

Do you have shortness of breath or other difficulty breathing? YES NO

Do you have a cough? YES NO

Any other flu-like symptoms, such as gastrointestinal upset, unexplained headaches or extreme fatigue? YES NO

Have you experienced a recent loss of taste or smell? YES NO

Have you been in contact with any confirmed or suspected COVID-19-positive patients in the last 14 days? YES NO

Have you traveled in the past 14 days out-of-country or to any regions heavily affected by Covid-19 (epicenters, e.g. New York City, etc.)? YES NO

Scanned Body Temperature _____