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Patient (S) temperature: ____

Patient Name (**if Minor**) : ____

I, (**PRINT NAME**) ____, knowingly and willingly consent to have any type of 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 it is impossible to determine who has it and who does not, given the current limits in virus testing.

SECTION 1: PATIENT TRAVEL/COVID-19 TESTING AND SYMPTOM HISTORY		**YES**	**NO**
1.	Have you or anyone in your household tested positive for COVID-19? If YES, When? ____		
2.	Have you or anyone in your household been tested and are awaiting results?		
3.	Do you have any of the following respiratory symptoms? Fever, Sore Throat, Cough, Shortness of breath?		
4.	Have you recently lost sense of smell or taste?		
5.	Do you have any GI symptoms? Diarrhea? Nausea?		
6.	Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?		

SECTION 2: PATIENT ILLNESS HISTORY (Please complete the following if you have been ill)		**YES**	**NO**
1.	Has at least 3 days (72 hours) passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in the respiratory symptoms (e.g., cough, shortness of breath)		
2.	Has at least 7days passed since symptoms first appeared?		

***Please notify the office if you have tested positive within 14-21 days after your dental appointment.**

Patient/Caregiver Signature: ___________________________________ Date: __________________

MASKS are required