Patient Name: _____ Ortho II Code: _____

Patient Request for Treatment, Representations and Consent

Dear Patient:

You have come to our office today for treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

We are following the infection control guidelines of the American Dental Association and the Centers for Disease Control to try to prevent the spread of the COVID-19 virus, but we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

If the answers to all of the questions is "no" and you acknowledge our representations above, please sign and date on the first available line.

If you answer "yes" to any of the questions, please inform a staff member and we will reschedule your visit.

Questions: Within the past 24 hours, have you had any of the following?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headaches
- New Loss of taste or smell
- Sore Throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- Within the past 14 days, have you had a known exposure to any individual suspected or confirmed to have COVID-19 or who has traveled to a location after which self-quarantine is recommended? For staff: You may answer "no" if you are a health care worker whose only exposure to individuals with suspected or confirmed COVID-19 has been in a health care setting in which you were wearing appropriate personal protective equipment.

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