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.

In order to reduce the risk of spreading COVID-19, we are asking you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

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

- Are you currently awaiting the results of a COVID-19 test?
- Do you have a fever?
- Do you have any shortness of breath?
- Do you have a dry cough?
- Do you have a runny nose?
- Do you have a sore throat?
- Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?
- Have you experienced headaches, fatigue, or weakness?
- Have you lost your sense of taste and/or smell?
- During the past 14 days, have you traveled by airplane, been within 6 feet of anyone else at a public gathering without wearing a mask, or had close contact with a person who has confirmed positive or suspected to be positive for COVID-19?

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