THIS FORM MUST BE COMPLETED REGARDLESS OF VACCINATION STATUS

DENTAL TREATMENT AMID THE COVID-19 PANDEMIC

We continue to heed all OSHA, CDC and CDA guidance related to Covid-19. Patients are required to complete this form, have their temperature taken, and wear a face mask in order to be seen.

Y N Are you experiencing more than one of the following symptoms: shortness of breath, dry cough, unexplained muscle pain, headache or nausea, new loss of taste or smell?

Y N Even if you don't have one of the above symptoms, have you experienced any of these in the last 14 days?

Y N Have you been exposed to a known or suspected Covid-19 positive individual in the last 14 days?

Y N Have you traveled outside of the state or country in the last 14 days?

Y N Have you been tested for Covid-19 in the last 14 days? (If you answer "No" skip the next question.)

Y N If you answered "Y" to the above, were the results were positive, inconclusive, or not yet received?

If you answered "Yes" to any of the above questions, we will help you to reschedule your appointment.

HEALTH HISTORY UPDATE

Please mark "Y" (yes) or "N" (no) for each item; for any marked Yes, please use the back of this page to provide details.

Y	**N**	Health Changes	**Y**	**N**	New/Current Health Conditions	**Y**	**N**	Medications
Y	**N**	Surgeries	**Y**	**N**	Pre-Medication Necessary	**Y**	**N**	Allergies
Y	**N**	Injuries / Accidents	**Y**	**N**	Hospital / Urgent Care Visits			

Patient Name:_______________________________________D.OB.:____________ Date:____________

Please sign and date to acknowledge that you have been consulted regarding today's treatment and had the opportunity to address any questions or concerns related to having this treatment, including any specific issues related to COVID-19.

Print Name if parent/guardian of above-named patient:____

Patient Signature:____Date:________________