DENTAL PATIENT SCREENING FORM AND INFORMED CONSENT COVID-19

Print name_____ Temp _____F

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _____ (Initial)
- I verify that I have not traveled within the United States by commercial airline, bus, or train within the past 14 days. _____ (Initial)
- I verify that I am not now presenting with nor have I had in the last 21 days any of the following symptoms of COVID-19 including: fever over 100.4F; shortness of breath; loss of sense of taste or smell; dry cough; runny nose; sore throat; difficulty breathing; or any flu like symptoms. _____ (Initial)
- I verify that I have not tested positive, nor been in contact with anyone diagnosed with, or suspected of having COVID-19 in the past 30 days. _____ (Initial)
- I verify that I have not been on a cruise or been in contact with anyone who has been on a cruise in the last 30 days. _____ (Initial)

Our office follows standard protocols to minimize the risk of infection. I understand dental procedures may create a risk of virus spread; this risk cannot be fully eliminated. _____ (Initial)

I understand that the COVID-19 virus is extremely contagious and is believed to spread by person-to-person contact, and that COVID-19 has been declared a worldwide pandemic. _____ (Initial)

I understand that COVID-virus can have a long incubation period during which people (including your healthcare providers) with the virus may feel and appear fine (asymptomatic) but still be contagious and very difficult to determine who has it and who does not. _____ (Initial)

I understand that social distancing is usually not possible with medical and/or dental treatments and providers and patients may not be able to social distance adequately. _____ (Initial)

I, _____, knowingly and willingly consent to have dental treatment during the COVID-19 pandemic. I hereby acknowledge and assume the risk of COVID-19 infection through dental procedures that may require medical attention if I have any positive COVID-19 diagnosis. I give my express permission for Dr. Ron Banik and the team at Carolina Family Dentistry/Ron Banik, DMD, PC to proceed with dental treatment.

Signature_____ Date_____