Hall Family Dentistry Supplemental Health History Questionnaire

COVID-19 (Coronavirus)

As a result of the possible community transmission of diseases, you could be exposed anywhere to infectious diseases including, but not limited to COVID-19 (also called Coronavirus). Our dental office is following the State, Federal, and CDC regulations and recommendations for universal personal protection and disinfection protocols to limit transmission of communicable diseases. Another way to limit the spread of coronavirus is to screen everyone for COVID-19 symptoms. Patients with COVID-19 symptoms should NOT receive dental treatment during their infections since this could lead to spreading the virus to other patients, the staff, the dentists, and all of their family members. **Please answer the below questions carefully.**

Have you, your child or others accompanying you to today's appointment tested positive for, been diagnosed, or been in contact with anyone having COVID-19? Yes____ No_____ If yes, when? Date: _____

Do you, your child or others accompanying you to today's appointment have/ have had recently:

YES	NO	
___	___	A fever or above normal temperature
___	___	A cough
___	___	Shortness of breath
___	___	Trouble breathing
___	___	Persistent pain, pressure, or tightness in the chest
___	___	A runny nose
___	___	Recently lost or had a reduction in your sense of smell
___	___	Do you have a sore throat?
___	___	Extreme fatigue or extreme muscle pain
___	___	Have you traveled outside of the US within the last 14 days?
___	___	Have you had contact with someone that has traveled outside of the US within the last 14 days?

If you have any of these symptoms or have recently tested positive for or been diagnosed with COVID-19, please reschedule your dental appointment. Preventing the spread of COVID-19 is everyone's responsibility. Do you acknowledge and accept the risk of exposure in our dental office to a communicable disease, included but not limited to COVID-19, and consent to treatment?

_____ _____

Patient/Parent's Signature Date

_____

Patient Printed Name