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Telephone: (732) 390-1911

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 Pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, 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 have asked 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.

_____ _____

**PATIENT/RESPONSIBLE PARTY** **DATE**

**PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:**

| | | |
|---|---|---|
| **ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?** | **YES** | **NO** |
| **DO YOU HAVE A FEVER?** | **YES** | **NO** |
| **DO YOU HAVE ANY SHORTNESS OF BREATH?** | **YES** | **NO** |
| **DO YOU HAVE A DRY COUGH?** | **YES** | **NO** |
| **DO YOU HAVE A RUNNY NOSE?** | **YES** | **NO** |
| **DO YOU HAVE A SORE THROAT?** | **YES** | **NO** |
| **DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO A SEASONAL ALLERGY?** | **YES** | **NO** |
| **HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?** | **YES** | **NO** |
| **HAVE YOU LOST YOUR SENSE OF TASTE OR SMELL?** | **YES** | **NO** |
| **WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELED TO ANY FOREIGN COUNTRY?** | **YES** | **NO** |
| **WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELED WITHIN THE UNITED STATES?** | **YES** | **NO** |

**IF SO, WHERE?** _____

_____ _____

**SIGNATURE OF PATIENT/GUARDIAN** **DATE**