



Patient Questionnaire – Addendum

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Do you have fever or experience fever within the past 14 days?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you experienced a recent onset of respiratory problems such as a cough or difficulty in breathing within the past 14 days?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you, within the past 14 days travelled to China, Italy, New Rochelle New York, and or any quarantined cities and/or its surrounding areas, or visited the neighborhood with documented Novel Coronavirus transmission? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you come into contact with a patient suspected or confirmed with the Coronavirus infection within the past 14 days?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you come into contact with people from neighborhood with documented Coronavirus transmission, or people from the neighborhood with recent documented fever or respiratory problems within the past 14 days?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you been in contact with anyone with documented experience of fever or respiratory problems within the last 14 days?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you recently participated in any gathering, meetings, or had close contact with any unacquainted people?   | <input type="checkbox"/> | <input type="checkbox"/> |

Temperature at visit: \_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## COVID-19 Pandemic Emergency Dental Treatment Consent Form

I, \_\_\_\_\_, knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. \_\_\_\_\_ (Initial)
- I have been made aware of the CDC, ODA, and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. \_\_\_\_\_ (Initial)
- I confirm I am seeking treatment for a condition that meets these criteria. \_\_\_\_\_ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- \_\_\_\_\_ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. \_\_\_\_\_ (Initial)

- 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 domestically within the United States by commercial airline, bus, or train within the past 14 days. \_\_\_\_\_ (Initial)

Name \_\_\_\_\_

Date \_\_\_\_\_