South Riding
COSMETIC & FAMILY DENTISTRY

HEALTH SCREENING QUESTIONNAIRE
INFORMED CONSENT/PATIENT DISCLOSURE

Welcome to South Riding Cosmetic & Family Dentistry-

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. A weakened or compromised immune system (including by not limited to conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose any conditions that put you at greater risk and understand that we may consider rescheduling your reservation.

1. In the last 14-21 days have you experienced any of the following: • A fever? • Shortness of breath or difficulties breathing? • A cough? • Flu-like symptoms such as gastrointestinal upset, headache, muscle aches/paints or fatigue? • Loss of taste or smell? • Chills or repeated shaking with chills? • A sore throat? • Quarantine?	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
2. Are you in contact with or caretaker for any confirmed COVID-19 positive patients? *Patients who are well, but have a sick family member at home should consider postponing elective treatment.*	Yes ☐ No ☐
3. Have you been tested COVID-19 positive?	Yes ☐ No ☐
4. Have you been tested for COVID-19 and awaiting results?	Yes ☐ No ☐
5. Are you over the age of 60?	Yes ☐ No ☐
6. Do you have heart disease, lung disease, kidney disease, diabetes or an auto-immune disorders?	Yes ☐ No ☐
7. Have you traveled in the past 14 days to any regions affected by COVID-19, including but not limited to China, Iran, countries in the European Union, the United Kingdom or Ireland?	Yes ☐ No ☐

I fully understand and acknowledge the above information, risks, and cautions and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

Patient/Guardian: _____ Date: _____

FOR OFFICE USE ONLY: P. R. Yes ☐ No ☐ **If yes, signature**_____