APEX DENTAL STUDIO

Patient Screening Form

This form is completed at every visit.

Have there been any of the following experienced in the past 48 hours? (circle yes or no)

• Fever of 100° F or greater and/or chills	Yes	No
• Cough (persistent) or shortness of breath	Yes	No
• Fatigue, headache muscle or body aches	Yes	No
• In contact with anyone currently positive for COVID-19	Yes	No
• Loss of taste or smell	Yes	No
• Sore throat	Yes	No
• Congestion/runny nose	Yes	No
• Nausea, vomiting or diarrhea	Yes	No

Are you high risk? Yes No

Age 60+, heart disease, lung disease, kidney disease, diabetes or auto-immune disorders

Our goal is to provide a safe environment for our patients, staff and community. The COVID-19 virus is serious and highly contagious. All patients and staff have vitals (temperature and pulse ox) taken prior to entry into treatment. Our practice wants to ensure you are aware of the additional risk contracting COVID-19 associated with dental care.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air, allowing for transmission of the COVID-19 virus nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need to access your mouth to render care. This leaves you and your provider vulnerable to COVID-19 transmission while receiving dental treatment.

Regardless of current state or local mandates, and in accordance with the American Dental Association, I understand face coverings are required when entering Apex Dental Studio and while in common areas of the practice.

I have read and acknowledged the information above and agree to follow any established protocol as directed by this medical facility.

_____ _____ _____

Patient Name Signature [patient, parent/guardian] Date