MOORE DENTAL CARE
You'll Leave Us Smiling Moore

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Screening and Acknowledgement Form for Dental Examination and Treatment during COVID-19 Pandemic

Please fill out this form on the day of your appointment.

Name: _____ Date of birth: _____

Please answer "yes" or "no" with your initials to the following questions:

___Yes ___No Do you have a fever?
___Yes ___No Do you have shortness of breath?
___Yes ___No Do you have dry cough?
___Yes ___No Do you have runny nose?
___Yes ___No Do you have sore throat?
___Yes ___No Do you have sneezing, watery eyes, or sinus discomfort not related to seasonal allergies?
___Yes ___No Do you have fatigue, weakness or headaches?
___Yes ___No Do you have loss of sense of taste and/or smell?
___Yes ___No Are you currently awaiting the results of a COVID-19 test?
___Yes ___No Have you traveled outside USA or to a high-risk city for COVID-19 in the past 14 days?
___Yes ___No Have you been in close contact to a known COVID-19 positive patient in the past 14 days, to the best of your knowledge?

I understand that this office screens all patients and staff for possible COVID-19 infection per the current guidelines. Carriers of the virus may be completely asymptomatic and still be contagious. Some may never develop full blown symptoms. This virus may spread through droplets or contact. Certain Dental procedures create water mist (aerosol) which may be one way the virus spreads. The aerosol and thus the virus may linger in the air for hours after certain dental procedures. Presently, it is impossible to determine who is an asymptomatic carrier. While this office strictly adheres to the OSHA/CDC standards as they currently exist, Coronavirus is a new, highly contagious pathogen that can be transmitted to and from healthcare workers even under strictly followed OSHA/CDC standards.

- I understand that due to other dental patients visiting the office and due to the characteristics of the virus and dental procedures, I have an elevated risk of contracting the virus simply by being in a dental office. _____ **(Initial)**

- I understand the CDC recommends social distancing of at least 6 feet, and this is not possible when seeking dental care. _____ **(Initial)**

- I have been informed of the $10 PPE fee (ADA code D1999) which will be assessed at EVERY appointment. This is a shared cost to cover the rising and additional costs of extra Personal Protective Equipment and other Enhanced Infection Control Measures used to further protect patients and staff during the COVID-19 Pandemic. I accept this fee in full regardless of insurance coverage, guidelines or benefits. In the event that my insurance plan shares this cost with me, I understand I will receive a credit on my account for use toward future treatment. _____ **(Initial)**

By signing below, I confirm that I have been informed of the risks associated the COVID-19 Pandemic and consent to being seen and treated in this office.

Signature_____ Date_____

For Staff Use:
Pt Temperature: _____°F Staff Initials_____ ☐Caregiver ☐ Translator ☐ Parent of Minor