Temperature: _____

Parkway Family Dentistry
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TELEPHONE (804) 750-1284

Patient Advisory and Acknowledgment Receiving Dental Treatment During COVID-19 Pandemic

Patient Name: _____ DOB: _____

In order to reduce the risk of spreading COVID 19, please complete a number of screening questions below. **For the safety of our team, other patients, and yourself, please be truthful and candid in your answers.**

Have you or anyone close to you experienced flu-like symptoms within the past 14 - 21 days such as:

Cough – wet or dry	_____yes _____no
Fever or felt hot / feverish	_____yes _____no
Shortness of Breath / Difficulty Breathing	_____yes _____no
Sore Throat	_____yes _____no
Muscle/Body Aches	_____yes _____no
Nausea/Vomiting/Stomach upset	_____yes _____no
Fatigue or Headache	_____yes _____no
A recent loss of taste or smell	_____yes _____no
Runny Nose	_____yes _____no

Have you, or anyone you have come into contact with, traveled out of state or outside of the country within the last 21 days? If yes, where?

_____

Have you come into contact with anyone who has tested positive for COVID-19? _____yes _____no

Have you been tested for COVID-19, with either a positive or negative result? _____yes _____no

Do you have an autoimmune disorder or on any immunosuppressive medication or steroids?_____yes _____no

Have you been diagnosed and /or treated for heart disease, lung related disease, kidney disease, cancer, diabetes or autoimmune disorder? _____yes _____no If yes, please specify:

_____

Do you currently smoke or vape or have you stopped within the past 2 years? _____yes _____no

Persons over 65 are at a higher risk. Are you over the age of 65? _____yes _____no

Our practice complies with the State Health Department and the CDC infection control guidelines to prevent the spread of the COVID-19 virus; however, we cannot make any guarantees. Our team is screened daily and, to the best of their knowledge, have not been exposed to the virus. We are a place of public accommodation, and other persons (including other patients) could be infected, with or without their knowledge. I hereby knowingly and willingly consent to have dental treatment completed at this time. I will hold harmless and indemnify the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions, in exchange for dental treatment during the events of COVID-19 National Emergency. I make this decision of my own free will relying upon my knowledge and judgement of any injury I may have sustained or possible transmission of COVID-19 during treatment and my decision to release has not been affected by any false statements or representations pertaining to those injuries. I have carefully read this release and understand its contents, and I am signing it of my own free act.

Patient Signature: _____ Date: _____

Witness Signature: _____