Crestpointe DENTAL

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Covid-19 Patient Screening Form

Instructions for use: Please fill this form no more than two days before your appointment.

Patient/Parent/Guardian Names: _____

Screening questions	1-2 days before appointment Date: / / Staff initial:____	day of appointment Date: / / Staff initial:____	Notes
Do you have a fever or above-normal temperature (>100.0° F)? *Take temperature at appointment.*	◯ No ◯ Yes	◯ No ◯ Yes	
Are you experiencing shortness of breath or having trouble breathing?	◯ No ◯ Yes	◯ No ◯ Yes	
Do you have a dry cough?	◯ No ◯ Yes	◯ No ◯ Yes	
Do you have a runny nose?	◯ No ◯ Yes	◯ No ◯ Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	◯ No ◯ Yes	◯ No ◯ Yes	
Do you have a sore throat?	◯ No ◯ Yes	◯ No ◯ Yes	
Are you experiencing chills or repeated shaking with chills?	◯ No ◯ Yes	◯ No ◯ Yes	
Do you have unexplained muscle pain?	◯ No ◯ Yes	◯ No ◯ Yes	
Do you have a headache?	◯ No ◯ Yes	◯ No ◯ Yes	
Are you experiencing nausea, vomiting or diarrhea?	◯ No ◯ Yes	◯ No ◯ Yes	
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	◯ No ◯ Yes	◯ No ◯ Yes	

Screening questions	Date: / / Staff initial:____	Date: / / Staff initial:____	Notes
Have you been in unprotected contact with someone who has tested positive for COVID-19 in the last 14 days? "Unprotected contact" means without the use of personal protective equipment.	◯ No ◯ Yes	◯ No ◯ Yes	
Have you been tested for COVID-19 in the last 14 days? *If "no," proceed to next question.*	◯ No ◯ Yes	◯ No ◯ Yes	
***If yes**, what is the result of the testing?* ***If negative,** proceed to next question.* ***If still waiting on results,** schedule appointment after results are known.*	◯ No ◯ Unsure ◯ Positive	◯ No ◯ Unsure ◯ Positive	
Have you traveled more than 100 miles from your home in the last 14 days?	◯ No ◯ Yes	◯ No ◯ Yes	
Have you received this season's flu vaccination? Date received: _____	◯ No ◯ Yes	◯ No ◯ Yes	

Patient signature required at appointment:

I agree to notify the dental practice if within 2 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had close contact with tested positive for COVID-19 within 2 days.

Acepto dar aviso a la clínica dental si dentro de dos días presento síntomas de COVID-19 o tengo un resultado positivo de COVID-19. Entiendo que la clínica dental tiene la obligación legal y ética de informarme si un miembro del personal con el que tuve contacto ha tenido un resultado positivo de COVID-19 dentro de dos días.

Signature_____

COVID-19 Dental Treatment Consent Form:

I consent to have a dental treatment completed during the COVID-19 transition period.

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

Dental procedures can create water spray which is one pathway that the disease spreads. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus. We have addressed this issue with the use of engineering controls (HEPA filters, UV-C, high volume evacuation) and enhanced disinfection controls.

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 the dental office.

Signature: _____