**Patient Advisory and Acknowledgment**

**Receiving Dental Treatment During the COVID-19 Pandemic**

We comply with Illinois State Health Department and the CDC infection control guidelines to help prevent the spread of the COVID-19 virus. Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. Other patients entering this facility are also symptom-free and claim to not have been in contact with any known infected person for the past 14 days.

**In order to reduce the risk of spreading COVID-19, we need you to answer “screening” questions.**

**Please answer “YES” or “ NO”. If you are a guardian answer for yourself and the patient.**

1) Do you have a fever or chills within the last 3 to 4 days? YES NO

2) Do you have shortness of breath or difficulty breathing? YES NO

3) Do you have a cough? YES NO

4) Do you have other flu-like symptoms:

fatigue, headache, gastrointestinal upset? YES NO

5) Do you have recent loss of taste or smell? YES NO

6) Have you or anyone in your household ever tested POSITIVE for Covid-19? YES NO

7) Do you have heart disease, lung disease, kidney disease, diabetes or…

 Any auto-immune disorders? YES NO

8) To the best of your knowledge have you been in contact with anyone

 With COVID-19 in the last 14 days? YES NO

9) Have you traveled in the past 14 days out of the country or to a region

 highly affected by COVID-19 (as relevant to your location)? YES NO

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temperature:\_\_\_\_\_\_\_\_\_\_

I agree to inform the office if I develop any of these symptoms or test positive for COVID-19 within the next week.