CHESTNUT DENTAL
YOUR SMILE'S IN GREAT HANDS

COVID Screening **Patient Temp:_____**

BP: _____

Have you or anyone in your family/household had :

Contact with anyone confirmed or under investigation for the COVID-19 virus? Yes___ No___

A fever within the last 14-21 days? Yes___ No___

Any flu-like symptoms such as gastrointestinal upset, headache, or fatigue? Yes___ No___

Loss of Smell or Taste? Yes___ No___

Sore throat? Yes___ No___

Cough? Yes___ No___

Runny nose? Yes___ No___

Shortness of breath or other difficulties breathing? Yes___ No___

Age over 65 ? Yes___ No___

Do you have heart, lung or kidney disease, diabetes or any autoimmune disorder? Yes___ No___

Informed Consent

We are and have always followed the state and federal recommendations on universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so. Despite our utmost careful attention to sterilization, disinfection and use of personal barriers, there is still a chance that you could be exposed to an illness in our office. We have taken measures to provide as much social distancing as possible, but due to the nature of the procedures we provide, it is not possible to maintain social distance between patients and staff at all times.

I understand that due to the visits of other dental patients, the characteristics of the virus, the characteristics of the dental procedure, that I may have an increased risk of contracting the virus by being in the dental office.

If age over 65 or underlying medical conditions I understand I am at a higher risk of complications if exposed to COVID.

Although we are doing everything possible to minimize risk of disease transmission, do you accept the risk and consent to treatment? Yes___ No___

Patient Name: _____ Date: _____

Signature (Patient or Guardian) _____