COVID-19 PATIENT PRETREATMENT & SCREENING FORM

Due to the COVID-19 global pandemic, we ask that you read and sign this form prior to arriving at our office and return it to us via email at office@jclaytondmd.com.

In order to safeguard our dental office and the rest of our community, we ask that you arrive at the office wearing a face mask. **You will not be allowed entry without a face mask**. If you are experiencing any symptoms related to COVID-19, we ask that you do not come to our office at this time and you reschedule your appointment. Symptoms are indicated below. This list is not all inclusive.

- Do you/they have a fever or you/they felt hot or feverish recently (14-21 days)?
- Are you/they having shortness of breath of other difficulties breathing?
- Do you/they have a cough?
- Do you/they have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?
- Have you/they experienced recent loss of taste or smell?
- Have you/they traveled in the past 14 days to any regions affected by COVID-19?
- (as relevant to your location)
- Are you/they in contact with any confirmed COVID-19 positive patients?
- Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.

Positive responses to any of the above would likely indicate a need to reschedule your appointment for at least 14 days. I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system. By signing this document, I acknowledge that I am not experiencing any symptoms related to COVID–19 nor have I been exposed to any confirmed COVID-19 positive patients.

Patient Signature:_____ Date:_____

If you are unable to print and/or email this form to us, please copy and paste this form into a composed email and send it to: office@jclaytondmd.com before your scheduled appointment.