Communicable Diseases Consent/Questionnaire

With community transmission of communicable diseases, you could be exposed anywhere to infectious diseases including, but not limited to COVID-19 (also called Coronavirus). Our office is following the State and Federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of communicable diseases. Though, it is possible that these precautions will not always be successful in blocking the transmission of these diseases. Social distancing nationwide has reduced the transmission of COVID-19; however, it is not possible to provide your endodontic treatment with social distancing between the patient, the doctor, our staff and possibly other patients.

By presenting yourself or your child for treatment, you assume and accept the risk that you or your child may inadvertently be exposed to a communicable disease.

If you have been exposed to a communicable disease prior to your appointment you may spread the disease to our team or to other patients in the practice. Therefore, prior to each appointment, we require you to answer the following questions:

Have you or others in your immediate household been tested for or diagnosed as having COVID-19?

Yes, Positive_____ Yes, Negative_____ No_____

If yes, when? Date of Positive Test_____ Date of Negative Test_____

Temperature: _____

Do you, or others in your immediate household, have:

Fever	Yes_____	No_____
Cough	Yes_____	No_____
Shortness of Breath and /or Trouble Breathing	Yes_____	No_____
New loss of taste or smell	Yes_____	No_____

By signing below, you acknowledge and accept the risk of exposure in our office to a communicable disease, included but not limited to COVID-19, and consent to treatment.

_____
Print Name

_____ _____
Signature Date