

Patient Advisory and Acknowledgment

Receiving Orthodontic Treatment During the COVID – 19 Pandemic

Dear Patient:

In order to reduce the risk of spreading COVID-19, we are asking you a number of questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PLEASE ANSWER “YES” OR “NO” WITH YOUR INITIALS TO THE FOLLOWING QUESTIONS:

Have you or anyone in the house been exposed to a COVID-19 patient? _____YES
_____NO

Do you have a fever? _____YES
_____NO

Do you have any shortness of breath? _____YES
_____NO

Do you have a rash or skin redness? _____YES
_____NO

Do you have a dry cough? _____YES
_____NO

Do you have a runny nose? _____YES
_____NO

Do you have a sore throat? _____YES
_____NO

Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual
and not related to seasonal allergies? _____YES
_____NO

Have you experienced headaches, fatigue, or weakness?
_____YES _____NO

Have you lost your sense of taste and/or smell? _____YES
_____NO

Within the last 14 days, have you or any family member travelled to any
foreign country? _____YES
_____NO

You have come to our office for orthodontic treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

Our office complies with recommendations from the Centers for Disease Control and the American Dental Association to prevent the spread of the COVID-19 virus; however, we cannot make any guarantees.

Our staff is symptom-free and, to the best of our knowledge, has not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected.

I consent to have orthodontic treatment at this time and into the future and authorize Dr. Rosen and his staff to do so.

_____ **Patient/Responsible Party**

_____ **Date**