PATIENT ADVISORY AND ACKNOWLEDGEMENT

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Dear Patient,

You have presented to the office today because you have a priority dental condition that should be treated at this time and should not be postponed until the current COVID-19 risk period has concluded. Please be advised of the following:

- While our office complies with the State Health Department and the Center for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- Our staff is symptom-free and checked daily. To the best of their knowledge they have not been exposed to the virus. However, since we are a place of public accommodation other persons (including other patients) could be infected with COVID-19 with or without our knowledge.
- COVID-19 virus is highly contagious and has a long incubation period. You are at a higher risk of contracting this virus while receiving dental care or in a dental office.

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

Please circle "YES" or "NO" to the following questions:

1. Have you had any flu-like symptoms in the last 7 days? (including fever, cough, or congestion) YES NO
2. Have you travelled in the last 14 days? YES NO

a. If yes, where? _____

3. Have you been in contact with anyone diagnosed with COVID-19? YES NO

By signing below I attest that have read and my answers are honest and true to the best of my knowledge

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

_____ Patient's

Temp:_____

PRINT NAME

Please sign below

AFTER THIS APPOINTMENT, IF I EXPERIENCE ANY SYMPTOMS OF COVID-19 WITHIN 48 HOURS OF BEING HERE, I MUST CONTACT US CAMBRIDGE FAMILY DENTAL at (763) 689-5699.

X_____ Staff initals_____