Renick Orthodontics

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COVID - 19 QUESTIONNAIRE AND CONSENT

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of ALL diseases in our office and continue to do so. Despite our 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, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Keeping this in mind, we have instituted additional measures in the office to follow extended CDC guidelines and dental board mandates, one of which is this Covid Questionnaire which the dental board is requiring to be recorded for each patient visit.

Patient Name: _____ Date: _____

FROM THE OHIO STATE DENTAL BOARD: To minimize the risk of COVID-19 symptomatic patients, we are implementing this Communicable Disease Screening Questionnaire [CDS form] established by the Ohio State Dental Board. All the questions below need to be asked and recorded. We appreciate your help and consideration for the good of the community to aid us in ensuring that we are doing everything possible to limit the spread of disease.

Please circle your answers

1. Has the patient or anyone in your immediate family been in contact with someone who is sick within the past 7 days?

Yes No

2. Has the patient or anyone in your immediate family traveled internationally in the last month? (If yes, list all places traveled.)

Yes No List of places travelled:

3. Has the patient or anyone in your immediate family been in contact with someone who has traveled internationally in the last month? [Concerns for COVID-19 exist for travel to China, Iran, South Korea and Italy but this may change in the near future]

Yes No

4. Does the patient or anyone in your immediate family have any of the following symptoms? (circle)

Fever Cough Shortness of Breath Muscle Pain Abdominal pain

Vomiting Diarrhea Severe Headache Red Eye Weakness

IF YOU ANSWER YES TO ANY OF THE QUESTIONS, THE PATIENT WILL NEED TO BE RESCHEDULED.

I attest that I have answered the above questions as completely and truly as possible and that I understand the risk of transmission of communicable diseases. By signing this form, I consent to continued treatment for the patient.

_____

Signature