WOODLAND HILLS DENTAL CARE

COVID-19 Screening and Treatment Consent Form

Print Name _____

1. Have you had a fever above 100.0 in the past 48 hours?

YES NO

2. Are you currently experiencing one or more of the following symptoms:

Shortness of breath	YES	NO
Cough	YES	NO
Sore throat	YES	NO
Muscle aches	YES	NO
Headache or nausea	YES	NO
New loss of taste or smell	YES	NO

3. Have you recently been in contact with someone who has tested positive for COVID-19?

YES NO

4. Have you recently tested positive, or are you currently awaiting test results, for COVID-19?

YES NO

As a team, we are doing everything in our power to protect you the patient, team members, and ourselves. We are following all recommended safety guidelines from CDC, CDA, and DPH. We are utilizing personal protective equipment, and have implemented additional cleaning and disinfecting protocols. Our office has also installed additional air purifiers to help minimize aerosols, and keep everyone safe.

By signing below, you acknowledge that you have answered the questions on this screening honestly, and consent to understanding the risks and undergoing dental treatment during the ongoing COVID-19 pandemic.

_____ _____

Signature Date