COVID-19 ACKNOWLEDGEMENT OF RISK AND HEALTH SCREENING FORM

______________________________ ______________________

Patient's Name Date of Birth

Our practice wants to ensure you are aware of the relative risks of exposure to COVID-19 associated with receiving treatment. This practice has always followed the applicable state and federal regulations and recommendations regarding infection control, sterilization, disinfection, and the use of PPE (personal protective equipment). We also work to protect our patients and office staff from virus spread by promoting frequent hand washing and office cleaning, using PPE for patient encounters, and adding additional environmental controls in the treatment areas.

Although we are using enhanced infection control measures in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing during treatment or for you to wear a mask during treatment. This means that the risk of exposure to COVID-19 remains when receiving treatment during the pandemic.

COVID Health History

Have you ever been diagnosed with COVID-19?	YES	NO	If yes, when? ________
Have you ever been hospitalized for COVID-19 treatment?	YES	NO	If yes, when? ________
Are you fully vaccinated or in the course of being vaccinated for COVID-19?	YES	NO	
Have you been tested for COVID-19 and are awaiting results?	YES	NO	
In the last 14 days, have you been in contact with any confirmed cases of COVID-19?	YES	NO	

Symptoms – Today, or in the last 14 days:

Have you had a fever or felt hot or feverish?	YES	NO
Have you had any shortness of breath or other breathing difficulties?	YES	NO
Have you had a cough?	YES	NO
Have you had any other flu-like symptoms, such as an upset stomach, headache, or fatigue?	YES	NO
Have you had a loss of taste of smell?	YES	NO
Have you otherwise felt unwell?	YES	NO

Patient Acknowledgement - By signing this document, I acknowledge that I have read the Patient Acknowledgment and that I understand and accept that there is a risk of COVID-19 exposure with treatment. I also acknowledge that the Health History and Health Screening answers I have provided are true and accurate.

______________________________ ____________

Patient or Legal Representative Signature Date

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Print Patient or Legal Representative Name/Relationship

__________________________ ____________

Witness Signature Date