Patient Advisory and Acknowledgment

Receiving Medical Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine medical evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, 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 or without their knowledge.

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

_____ _____

PATIENT/RESPONSIBLE PARTY **DATE**

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?	_____	**YES**	_____	**NO**
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? YES NO	_____		_____	
DO YOU HAVE A FEVER? YES NO	_____		_____	
DO YOU HAVE ANY SHORTNESS OF BREATH? 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 TRAVELLED TO ANY FOREIGN COUNTRY? YES NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES

OR TO ANY FOREIGN COUNTRY? YES NO

IF SO, WHERE?