BRIGHT SMILES DENTAL, 1234-EAST LINCOLN HIGHWAY, LANGHORNE, PA-19047

PATIENT PRE- SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy

Patient name : ______________________________

Patient DOB: ______________________________

	DATE :
Do you have fever or felt feverish recently ? (14-21 days)	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No
Any other flu-like symptoms, gastro-intestinal upset, headache or fatigue ?	☐ Yes ☐ No
Have you experienced recent loss of taste or smell ?	☐ Yes ☐ No
Are you in contact with any confirmed COVID-19 positive patients ?	☐ Yes ☐ No
Are you over the age of 60 years?	☐ Yes ☐ No
Do you have any heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No
Have you traveled in the past 14 days to any regions affected by COVID-19?	☐ Yes ☐ No

I am aware that wrong responses can adversely affect my health and also the health of the dental team.

Patient signature: ______________________________

Parent / Guardian name: ______________________________

Parent / Guardian signature: ______________________________

OFFICE USE ONLY:

Temperature: ____________

Pulse : ____________

Doctor signature : ____________

BRIGHT SMILES DENTAL,
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COVID-19 Pandemic Emergency Dental Treatment Consent Form

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. Given the current limits of COVID-19 virus testing, it is impossible to determine who is infected with COVID-19 and who is not. Some dental procedures create aerosoles which is how the disease can be transmitted. The ultra-fine nature of aerosol spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

*I understand that due to the scheduling frequency of appointments of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I / my child have an elevated risk of contracting the virus simply by being in a dental office. __________ (Initial)

*I have been made aware of the CDC, ADA, and PDA guidelines that under the current pandemic, all non-emergent Dental Care is not recommended. Dental treatment should be limited to the treatment of pain, infection ,conditions that significantly inhibit normal functions of the teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. __________ (Initial)

*I I confirm that I am seeking treatment for myself / my child for a condition that meets these criteria. __________ (Initial)

*I confirm that I / my child are NOT presenting any of the following symptoms of COVID-19 that are listed below:

*Fever
*Shortness of Breath
*Dry Cough
*Runny Nose
*Sore Throat
*Loss of taste/smell senses
_____________ (Initial)

*I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and that this is not possible during the dental treatment procedure.
_____________ (Initial)

*I verify that I / my child have NOT traveled outside of the United States in the past 14 days to countries that have been affected by COVID-19. __________ (Initial)

* I verify that I / my child have NOT traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. __________ (Initial)

I am knowingly and willingly consenting to these procedures for myself / my child with the full understanding and disclosure of such risks and alternatives associated with the COVID-19 pandemic, and all of my questions were answered to my satisfaction.

Patient name :____________________________________

Patient Signature:____________________________________

Date:________________________________

Parent/Guardian Signature:____________________________

Printed Name Of Parent/Guardian:____

Relationship To Patient:____

Dentist Signature:____________________________________

Date:_______________