Justin A. Shuffer, DDS, INC

COVID-19 Health Questionnaire Consent and Agreement Form

Patient Name:____ Birthdate: _________________

In order to reduce the risk of spreading COVID-19, we are asking some screening questions below.

Have you, your child, others accompanying you to today's appointment, or other recent acquaintances tested positive for or been diagnosed as having COVID-19?

☐ Yes ☐ No If yes, When? Date: ___________________

Have you or anyone else in your household had any contact with anyone diagnosed with COVID-19 or be suspected of having COVID-19?

☐ Yes ☐ No If yes, When? Date: ___________________

Do you, your child, or others accompanying you to today's appointment or other recent acquaintances/contact have:

- A Fever, or Have You Felt Feverish (defined as above 100.4 degrees) ☐ Yes ☐ No
- A Cough? ☐ Yes ☐ No
- A Sore Throat? ☐ Yes ☐ No
- Shortness of Breath and/or Trouble Breathing? ☐ Yes ☐ No
- Persistent Pain, Pressure, or Tightness in the chest? ☐ Yes ☐ No
- Traveled out of the country or been on a cruise ship in the past 8 weeks? ☐ Yes ☐ No
- Body Aches and Pains? ☐ Yes ☐ No
- Unusual Rash or Skin Irritations? ☐ Yes ☐ No
- Loss of Appetite? ☐ Yes ☐ No
- Diarrhea? ☐ Yes ☐ No
- Loss of Taste or Smell? ☐ Yes ☐ No
- Discoloring of Toes and Fingers? ☐ Yes ☐ No
- Chills or repeated shaking with chills? ☐ Yes ☐ No
- Headaches? ☐ Yes ☐ No

I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's appointment. If you or your child start feeling ill with the symptoms of COVID-19 within 14 days of your appointment, please call this office and your primary care physician immediately.

Thank you for your continued trust in our practice. Please be assured that, as a matter of routine office protocol, the doctors and support staff members of Justin A. Shuffer, DDS, Inc have always strictly followed state and federal regulations and guidelines relating to infection control protocols established for limiting transmission risk of all potentially communicable diseases in our dental clinic. We will of course continue to do so with an even heightened attention to detail in light of the current pandemic environment. As is the case with transmission of most all contagious illnesses, such as a common cold or seasonal flu, you and/or your child may have recently been exposed to a virus called **novel SARS-CoV-2** that can cause a disease known as **COVID-19**. *Social Distancing* nationwide has shown to be effective in reducing the transmission of *novel* SARS-CoV-2, and although we have taken measures to provide for social distancing (6 feet) in our practice, due to the nature of the procedures we provide, it is not possible to maintain *ideal* social distancing between the patient, dentist, staff and/or other patients at all times.

Do you accept the risk and consent to treatment? ☐ Yes ☐ No

Do you and everyone in your party agree to wear a mask at all times and make every attempt to socially distance 6 feet from others? ☐ Yes ☐ No

____ _____________________

Patient Name/Parent's Signature/relationship to Patient Date

We are looking forward to seeing you at your next appointment. Please email or bring the Covid-19 questionnaire consent form on the day of your appointment. When you arrive to our office, please call or text us. An assistant will come to your car and take temperatures of everyone in the car. This is our new protocol to make your visit safe.

To help limit the chance of exposure, we ask that you understand that our waiting room will be closed until further notice. Therefore, to be seen we ask that:

- You wait outside and we will call you when it is time to be seen.
- Temperature checks will take place for all individuals
- **Only patients with appointments and one guardian** will be allowed to enter the office and everyone must wear a mask and practice social distancing.
- Please wash or sanitize your hands before entering the office. Hand sanitizing stations have been placed throughout the office for your use.
- Please wear a face mask at all times and make every attempt to socially distance 6 feet from others.
- Please note that if you cannot abide by these rules and refuse to sign this waiver we will not be able to see you in our office at this time, but you may be able to receive services through our teledentistry model. Thank you for your understanding and cooperation during these unprecedented times.

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Patient Name/Parent's Signature/relationship to Patient Date