The Grove Family Dentistry - COVID19 Patient Screening Form
(To be completed on date of dental treatment)

Patient/Guardian Names: _____ Date: _____

Temperatures: _____Flu Vaccine/Date:_____

Have you been tested? Test Results (Include Date and Reason):_____ COVID Vaccine/Dates:_____
If positive, and emergency care is not needed, reschedule after 10 days (20 days if severe) have passed since beginning of symptoms and 24 hours with temp <100.0 F without use of medications. If waiting for results (Reschedule after results are negative).

Screening Questions	No	Yes	Information
Do you have a fever or above normal temperature (>100.0 F)?			If yes, and emergency care is not needed, reschedule once symptoms resolve or negative COVID19 test.
Any shortness of breath or trouble breathing?			
Any coughing not due to allergies?			
Any nasal congestion or runny nose not due to allergies?			
Any sore throat?			
Any loss of smell or taste?			
Any chills?			
Any unexplained muscle pain?			
Any Unexplained headache?			
Any nausea, vomiting, diarrhea?			
Any of the above symptoms in the last 14 days?			If yes, and emergency care is not needed, reschedule after 10 days have passed since beginning of symptoms and 24 hours with temp <100.0 F without use of medications.
In the past 14 days, any contact with someone who has any of the above symptoms?			
In the past 14 days, any contact with someone who tested positive for COVID19 without use of personal protective equipment?			If yes, and emergency care is not needed, reschedule after 14 days have passed since last contact with that person.
In the past 14 days, any travel more than 100 miles from your home?			If yes, and location is an area of high cases, determine if social distancing was followed and mask was worn while in public.
In the past 14 days, any travel out of state/country?			
In the past 14 days, any group gatherings outside of own household?			
If yes, were you wearing a mask the entire time and practicing social distancing?			

Supplemental Informed Consent: Dental Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold, you may be exposed to COVID-19 ("Coronavirus"), at any time or in any place. Be assured that we continue to follow state and federal regulations as well as recommended universal personal protective equipment (PPE) and disinfection protocols to limit transmission of all diseases in our office.

Despite our careful attention to sterilization, disinfection and the use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be exposed at your gym, grocery store, or restaurant. Nationwide social distancing has reduced the transmission of the coronavirus. Although we have taken measures to enable social distaning in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental healthcare team members and sometimes other patients at all times.

Although exposure is unlikely, I knowlingly and willingly consent to have dental treatment completed during the COVID-19 Pandemic.

I agree to notify the dental practice if within 2 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a team member I had contact with tested positive for COVID-19 within 2 days.

Patient/Guardian Signature: _____ Date: _____