SanMarin
DENTAL CARE
Master Quality Gentle Dental Care

COVID-19 Patient Screening Form

Patient Name	**Before Appointment**	**In-Office Appointment**
Are you over 60 years of age?	YES/NO	YES/NO
Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	YES/NO	YES/NO
Are you experiencing shortness of breath or trouble breathing?	YES/NO	YES/NO
Do you have a temperature of 100.4° F or higher?	YES/NO	YES/NO
Are you experiencing a sore throat?	YES/NO	YES/NO
Are you coughing?	YES/NO	YES/NO
Are you experiencing repeated shaking with chills?	YES/NO	YES/NO
Do you have muscle aches?	YES/NO	YES/NO
Are you experiencing gastrointestinal changes?	YES/NO	YES/NO
Have you noticed a loss of smell or taste?	YES/NO	YES/NO
Have you had contact with a known or suspected COVID-19-positive person?	YES/NO	YES/NO
In the last 14 days, have you traveled to an area that has a high incidence of COVID-19?	YES/NO	YES/NO
If yes to the question above, please specify:		

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Patient Consent

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "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 favorite restaurant. Nationwide social distancing has reduced the transmission of the coronavirus. Although we have taken measures to enable social distancing 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, do you accept the risk and consent to treatment?

Yes_____ No_____

_____ _____

Patient/Parent's Signature Date