YOUNG orthodontics

CORONAVIRUS PATIENT CONSENT FORM

The Center of Disease Control identified nine symptoms associated with Coronavirus.

My Temperature at ___ : ___ am/pm is ____ºF. [The dental office will fill in this line.] You will be asked to leave if your temperature meets or exceeds 100.4 ºF. The CDC considers such a reading to indicate a fever.

Please complete all questions below. In the past 24 hours:

CoughYes: ___ No: ___ Muscle pain Yes: ___ No: ___

Headache Yes: ___ No: ___ Sore throat Yes: ___ No: ___

Shortness of breath or difficulty breathing Yes: ___ No: ___

Chills Yes: ___ No: _____ Loss of taste or smell Yes: ___ No: ___

Have you or a family member been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection? Yes: ____ No: ____

As of this morning, none of our doctors or staff exhibit any Coronavirus symptoms; however, we have NOT BEEN MEDICALLY TESTED for COVID-19 and cannot guarantee that either we or our other patients are Coronavirus-free.

For your safety, our office has increased hygiene measures since the outbreak.

Given this knowledge and knowing that I possibly could contract COVID-19 at this office (through the doctors, staff, or from other patients, and despite the office's best intentions), I nevertheless voluntarily wish to continue with my elective dental treatment and hold the doctor and staff harmless should I come down with Coronavirus.

I have read this page and the content in full and have no questions.

Dated this _____ day of _____, 2021.

_____
Patient Name

_____ _____
Patient Signature Temperature taken by (Initials)