



ASSOCIATES IN PERIODONTICS

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## COVID Patient Advisory and Acknowledgement

Sadly, the COVID pandemic is not yet over. In order to reduce the risk of spreading COVID-19 and the variants, the CDC still mandates that you wear a mask in the office and complete a number of "screening" questions below.

Print your name/Responsible Party \_\_\_\_\_

Date \_\_\_\_\_

1. Have you been FULLY vaccinated against COVID-19?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Have you ever been diagnosed with COVID-19? Date of diagnosis _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Do you live with or care for someone who has COVID-19?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Have you had a fever greater than or equal to 100.4° (T≥100.4°F) in the past 48 hours?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Do you have a sore throat?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Do you have a cough?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Are you experiencing any shortness of breath or difficulty breathing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Have you recently lost your sense of taste/smell?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Do you have a constant headache, body, or muscle aches?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Temperature: \_\_\_\_\_ F

**Any positive responses will be reviewed by the dentist.** If you have a temperature, the advice to follow-up with your personal healthcare provider may be indicated.