ASSOCIATES IN PERIODONTICS
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Patient Advisory and Acknowledgement

Receiving Dental Treatment During the COVID-19 Pandemic

Today we plan a hygiene visit, periodontal evaluation, or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

In order to reduce the risk of spreading COVID-19, we are asking a number of "screening'' questions below to help protect our staff, patients, and you.

____ _________________________
Patient name Date

Question		
1. Have you been FULLY vaccinated against COVID-19? IE. Had 3 or 4 shots	☐ YES	☐ NO
2. Are you experiencing any new headaches?	☐ YES	☐ NO
3. Are you experiencing new loss of taste or smell?	☐ YES	☐ NO
4. Are you suffering from chills (repeated shaking)?	☐ YES	☐ NO
5. Do you have a sore throat?	☐ YES	☐ NO
6. Are you experiencing a new cough?	☐ YES	☐ NO
7. Are you experiencing shortness of breath?	☐ YES	☐ NO
8. Do you have a fever of 100.0 degrees or more?	☐ YES	☐ NO
9. Are you suffering from myalgia (body aches)?	☐ YES	☐ NO
10. Are you suffering from congestion or a runny nose (not from allergies)?	☐ YES	☐ NO
11. Are you experiencing extreme fatigue, nausea, vomiting, or diarrhea?	☐ YES	☐ NO
12. Do you live with or spend time with someone who has COVID-19?	☐ YES	☐ NO

Positive responses to questions # 2 – #12 will be reviewed by one of the doctors.