

Patient Advisory and Acknowledgment

Receiving Medical Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine medical evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of “screening” questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____
DATE

PLEASE ANSWER “YES” OR “NO” WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

- ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? YES NO
- DO YOU HAVE A FEVER? YES NO
- DO YOU HAVE ANY SHORTNESS OF BREATH? YES NO
- DO YOU HAVE A DRY COUGH? YES NO
- DO YOU HAVE A RUNNY NOSE? YES NO
- DO YOU HAVE A SORE THROAT? YES NO
- DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? YES NO
- HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? YES NO
- HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? YES NO
- WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY? YES NO
- WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES? YES NO

IF SO, WHERE? _____