SOUTH FLORIDA
SMILE SPA
COSMETIC & SEDATION DENTISTRY
NICOLE M. BERGER, DDS

PATIENT ADVISORY AND ACKNOWLEDGMENT

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for dental 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 (DOH) and the Centers for Disease Control and Prevention infection (CDC) control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff and doctors 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 SCREENING FORM

PATIENT NAME:_____AGE:_____

	PRE-APPOINTMENT		**IN-OFFICE**	
	DATE:_____		DATE:_____	
Are you currently awaiting the results of a COVID - 19 test?	YES◯	NO ◯	YES ◯	NO◯
Do you have or have had a fever in last 14-21 days?	YES◯	NO◯	YES◯	NO◯
Do you have any shortness of breath or other breathing difficulties?	YES ◯	NO◯	YES ◯	NO◯
Do you have a dry cough?	YES◯	NO◯	YES◯	NO◯

Do you have any other flu-like symptoms, such as sore throat, runny nose, gastrointestinal upset headache, sneezing or fatigue not related to sinus? YES◯ NO◯ YES◯ NO◯

Have you experienced any recent loss of taste or smell? YES◯ NO◯ YES◯ NO◯

Have you had any contact with a confirmed COVID - 19 positive patient? YES◯ NO◯ YES◯ NO◯

Have you traveled in the past 14 days to any regions affected by COVID - 19 within USA? YES◯ NO◯ YES ◯ NO◯

If YES, state where:_____

Have you traveled in the past 14 days to any foreign countries? YES◯NO◯ YES◯ NO◯

If YES, state where:_____

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disease? YES◯ NO◯ YES◯ NO◯

If YES, please state which one:_____

PATIENT/RESPONSIBLE PARTY:_____DATE_____

DENTIST SIGNATURE:_____DATE_____