# COVID-19 Consent and Screening Form

1. I knowingly and willingly consent to dental treatment by Kenneth L. Andow D.D.S. and/or any designated hygienists/assistants during the reopening phase of COVID-19.
2. I understand that Dr. Andow is following ADA, CDC and OSHA recommendations to provide the safest and lowest risk environment to minimize the transmission of COVID-19.
3. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has it and who does not given the current limitations and availability in COVID-19 viral testing. I understand that dental procedures create aerosol (water spray) which is one way the disease can spread.
4. Risk of transmission: I understand that due to the frequency of visits of other dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though strict standard precautions are being observed.

| | IN-OFFICE |
|---|---|
| Patient Name: _____ | Date: _____ |
| Have you tested positive for COVID-19 in the last 30 days? | ☐ Yes ☐ No |
| Have you exhibited any cold or flu-like symptoms in the last 14 days (fever, cough, sore throat, muscle aches, chills, shortness of breath or other respiratory problems)? | ☐ Yes ☐ No |
| Have you experience recent loss of taste or smell? | ☐ Yes ☐ No |
| Have you had close contact with or cared for someone with a confirmed or suspected case of COVID-19 within the last 14 days? | ☐ Yes ☐ No |
| Are you over 65 years old? | ☐ Yes ☐ No |
| Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder? | ☐ Yes ☐ No |
| Have you recently traveled or been in close contact with anyone who has traveled within the last 14 days? | ☐ Yes ☐ No |
| Are you a first responder, healthcare worker, or an employee or attendee of a child or adult care facility? | ☐ Yes ☐ No |
| Temperature of Patient | _____°F |
| Temperature of Parent or Guardian | _____°F |

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____ _____

Parent or Guardian (if minor) Date