Implant Dentistry and Perio Rehab

2108 Virginia Drive, Ste A
Wichita Falls TX 76309

PATIENT HEALTH QUESTIONNAIRE & INFORMED CONSENT

PERIODONAL TREATMENT IN THE ERA OF COVID-19

Thank you for your trust in our practice. We have missed each of you and are excited to continue taking care of you! As with transmission of any communicable disease, such as the common cold or flu, you may be exposed to COVID-19 (sometimes called "Coronavirus") at any time or in any public place. If you have been exposed to a communicable disease, you could spread it to the dentist, dental staff or other patients or family members. To help protect those entering our practice space, we ask that you complete the questionnaire below prior to coming in for your appointment. If you answer "yest" to any of the following, we may ask to reschedule your appointment for the safety of our staff and other patients.

QUESTIONNAIRE: Have you or anyone who lives in your household, at any time in the last 14 days:

1. Been in contact with someone who in the last 14 days tested positive for COVID-19?
   ❑ Yes ❑ No
2. Tested positive for COVID-19?
   ❑ Yes ❑ No
3. Submitted for a test for COVID-19?
   ❑ Yes ❑ No
4. Had a fever (defined as above 99.6 degrees)?
   ❑ Yes ❑ No
5. Had any shortness of breath and/or trouble breathing?
   ❑ Yes ❑ No
6. Had persistent pain, pressure or tightness in your chest?
   ❑ Yes ❑ No
7. Had a cough or sore throat?
   ❑ Yes ❑ No
8. Traveled outside of the Wichita Falls TX area?
   ❑ Yes ❑ No

   If so, where? _____

INFORMED CONCENT: We are committed to compliance with all applicable health regulations and we routinely monitor applicable guidelines. Even with our careful attention to sterilization, disinfection, and use of personal barriers, and social distancing when possible when possible, there is still a chance that you could be exposed to an illness in our office. For example, due to nature of the procedures we provide, it is not possible to maintain social distancing between patient, dentist, dental staff, and sometimes other patients, at all times. By signing below, you acknowledge we have provided you with this information to make an informed consent to treatment at our office, and you confirm that you have answered questions 1 – 8, above, truthfully and to the best of your knowledge, and you consent to treatment.

Agreed to by or on behalf of Patient. _____ (Patient Name)
Signature: _____ Date: _____
Printed Name: _____ [ ] Patient / [ ] Parent / [ ] Guardian