

## SUPPLEMENTAL HEALTH QUESTIONNAIRE AND CONSENT

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff, or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Have you, your child, or other recent close contact or household members tested positive for or been diagnosed as having COVID-19 or any other communicable disease?

No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, when? Date \_\_\_\_\_

Does anyone attending today's appointment or recent close contacts have the following symptoms:

- A fever (defined as above 100.4 degrees)? No \_\_\_\_\_ Yes \_\_\_\_\_
- A cough? No \_\_\_\_\_ Yes \_\_\_\_\_
- Shortness of breath and/or trouble breathing? No \_\_\_\_\_ Yes \_\_\_\_\_
- Persistent pain, pressure, or tightness in the chest? No \_\_\_\_\_ Yes \_\_\_\_\_
- Altered or lack of smell or taste? No \_\_\_\_\_ Yes \_\_\_\_\_
- Have there been any recent changes in your medical history? No \_\_\_\_\_ Yes \_\_\_\_\_ (please explain)

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19 at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office. Social distancing measures nationwide have reduced the transmission of COVID-19. Although we have taken measures to provide social distancing between patients, it is not possible to maintain social distancing between the patient, orthodontist, and orthodontic staff at all times.

Although exposure is unlikely, do you accept the risk described above and consent to treatment?

Yes \_\_\_\_\_ (initial)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Parent's Signature

\_\_\_\_\_  
Date