Patient Temperature: _____

COVID-19 Screening Form

At Burleson Endodontics, the health and safety of our patients and staff has always been a top priority. To ensure we are providing the safest environment possible, we ask you to please complete this brief questionnaire before your appointment. We appreciate your help and understanding.

I,_____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and may still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus.

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____(Initial)

- I verify that I have not traveled outside the United States in the past 14 days to countriest that have been affected by COVID-19. _____(Initial)
- Have you traveled domestically within the United States by commercial airline, bus or train within the past 14 days? Yes / No (circle one).
    - If yes, when(dates)? _____

I confirm that I do not currently have or have had, in the last 14 days, any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath/Difficulties Breathing
- Loss of Sense of Taste or Smell
- Dry Cough
- Flu-like Symptoms (Gastrointestinal Upset, Headache or Fatigue)
- Runny Nose
- Sore Throat

_____(Initial)

Have you been in contact with any confirmed COVID-19 positive patients? Yes or No

Have you been tested for COVID 19 in the last 3 weeks? If so what were the results. + or - or awaiting

Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?
Yes or No

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.
By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Print Name_____Date_____

Signature_____Date_____