COVID-19 QUESTIONNAIRE COVID-19 QUESTIONNAIRE COVID-19 QUESTIONNAIRE

Boulevard Dental Associates, PA 2275 J F Kennedy Blvd Jersey City, NJ 07304 201.434.3819

Patient Name:_____ **Patient Temperature:**_____

Today's Date:_____ **Date of birth:**_____

PATIENT DISCLOSURE

A weak or compromised system (including, but not limited to conditions like **obesity**, **diabetes**, **asthma**, **COPD**, **cancer treatment, radiation, chemotherapy**, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19 or any communicable disease.

It is also important you disclose to this office any indication of having **been exposed to COVID-19**, or whether you are experiencing any signs of symptoms today.

	YES	NO
Do you have a cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled by air or cruise ship in the past 14 days?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Have you received the COVID-19 vaccine?	☐	☐
IF YES DID YOU GET THE BOOSTER? YES / WHAT DATE?.....NO ?		
Have you tested positive for Covid-19**? IF YES , WHAT DATE** ?_____	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a comprised immune system and have disclosed to this dental office 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.

X	X	X
Signature of patient	**(DATE)**	**Witness**

Covid-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

The World Health Organization has characterized COVID-19 virus, also known as "Coronvirus" as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving dental treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristic of dental procedures, there is an elevated risk of you contracting the virus simply by being in any dental office.

Dental procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Due to the nature of the procedures dentists provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgement

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic. I understand and accept the increased risk of COVID-19 exposure with treatment at this office. I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office unrelated to my visit here.

X	X	X
Signature of patient	**(DATE)**	**Witness**

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