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Advanced Dental Care

Screening Form

First Name* _____ Middle Initial* ___ Last Name* _____ D.O.B* _____

Cell Phone Number* ( ) _____ E-mail* _____

Please initial the (Yes or No) box responding to whether or not you have experienced any of the following symptoms in the last 14 days.*

Yes	NO		Yes	NO	
[ ]	[ ]	Fever	[ ]	[ ]	Diarrhea, Digestive Upset
[ ]	[ ]	Chills	[ ]	[ ]	Nasal, sinus congestion (not allergy induced)
[ ]	[ ]	Cough	[ ]	[ ]	Loss of taste or smell
[ ]	[ ]	Sore Throat	[ ]	[ ]	Shortness of breath
[ ]	[ ]	Fatigue	[ ]	[ ]	Sudden onset of muscle soreness
[ ]	[ ]	Rash or skin lesions (especially on the feet)			

I agree (please initial) to the following:

[ ] I understand the above symptoms and affirm that I, as well as those in my household, do not currently have, nor have experienced the symptoms above within the last 14 days.

[ ] I affirm that I, as well as those in my household, have not been diagnosed with COVID-19 (or any other contagious disease) within the last 14 days.

[ ] I affirm that I, as well as those in my household, have not traveled outside of the U.S. or to any city that is outside of our own that is or has been considered a "hot spot" for COVID-19 (or any other contagious disease) within the last 14 days.

[ ] I understand that Advanced Dental Care, it's dentist(s) and all staff members cannot be held liable for any exposure to COVID-19, nor any other contagious disease.

[ ] Upon arrival, I will call from outside and await permission to enter. No additional person – family or friend – will accompany me inside, unless given prior permission. Upon entering Advanced Dental Care's office, I will wear a mask and will use the provided hand sanitizer (wall dispenser straight ahead).

I declare that the information provided above is true.

I give my consent to be treated and release and hold harmless all members of Advanced Dental Care from any claims related to the above.

Date Signed* _____

Full Signature* _____