**Quality Dental, PLLC**

**5100 Southpoint Parkway**

**Fredericksburg, VA 22407**

**COVID-19 Pandemic
Dental Treatment Screening and Consent Form**

**At Quality Dental we place the health and safety of our patient’s and staff as our highest priority. We are following or exceeding all ADA and VDA guidelines.**

* I understand that – COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. Even after following protocols set by the American Dental Association and the Virginia Dental Association, it is still possible to contract COVID-19 while at a dental office. \_\_\_\_\_\_\_ (Initial)
* I confirm that I am not presenting any of these COVID-19 symptoms: \_\_\_\_\_\_\_ (Initial)
	+ Fever
	+ Shortness of breath
	+ Dry cough
	+ Runny nose
	+ Sore throat
* I confirm that I have not been in contact with a person who has been diagnosed with COVID19 within the past 14 days. \_\_\_\_\_\_\_ (Initial)
* I have been diagnosed with COVID-19. \_\_\_\_\_\_yes \_\_\_\_\_\_no

If yes, I verify that I have received medical clearance to end quarantine or have received negative test results with the cessation of all symptoms at least 14 days prior to entering the dental office. \_\_\_\_\_\_\_\_(Initial)

Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient) (Patient)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient or legal guardian)