Karabell Dentistry Covid-19 Questionnaire and Release

In an effort to protect our patients, team and the community, we ask you to kindly respond to the following questions:

_____(Initial) I agree that, If I were to exhibit any symptoms of, or be diagnosed with, COVID-19, I will immediately notify our office so that proper steps can be taken to limit the spread of the virus.

1. Have you had a fever, runny nose, sore throat, or any symptoms that resemble the flu or common cold within the past 10 days? Yes_____No_____
2. Have you experienced shortness of breath or any respiratory complications within the past 10 days? Yes_____No_____
3. Have you come in contact with any person(s) with confirmed COVID-19 or flu-like symptoms in the past 10 days? Yes_____No_____
4. Have you had a **Positive** COVID-19 test in the past 30 days? Yes_____No_____
    a. Date of Test _____

You are receiving dental/hygiene care during the events of a **Covid-19 National Emergency**. Please be advised that there may be risks in being in the proximity of dentists, patients, or staff. We are taking all necessary precautions to limit the spread of disease, yet there is still a possibility of transmission.

Thank you for your understanding.

Your team at Karabell Dentistry

_____ _____

Patient Date

_____ _____

Dr. Karabell Date