SUPPLEMENTAL INFORMED CONSENT & HEALTH QUESTIONNAIRE

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or flu, you may be exposed to COVID-19 at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so. Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or restaurants. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff, and sometimes other patients, at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment? ☐ YES ☐ NO

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff, or other patients/parents in the practice. Please answer the following questions to help reduce the chances of transmission. **This form will be considered valid for all future visits - if there is any change in medical history or to the answers of these questions, please let us know**.

Do you, your child, or anyone else you have recently been in contact with have any of the following symptoms?

- Fever? ☐ YES ☐ NO
- Chills? ☐ YES ☐ NO
- Cough? ☐ YES ☐ NO
- Sore Throat? ☐ YES ☐ NO
- Shortness of breath and/or difficulty breathing? ☐ YES ☐ NO
- Persistent muscle pain, pressure or tightness in the chest? ☐ YES ☐ NO
- New loss of taste or smell? ☐ YES ☐ NO

Have you or your child traveled outside of our local area or outside of the US within the past 14 days? ☐ YES ☐ NO

Have you, your child, or anyone you have recently been in contact with been diagnosed with COVID-19? ☐ YES ☐ NO

If you answered YES to the above question, please provide additional information.
Approximate date of illness:

_____ through _____
symptom start date symptom end date

or

Date of positive test: _____

_____
Patient Name Date

_____
Parent/Guardian Name *(if applicable)*

_____
Patient/Parent/Guardian Signature