Flores
DENTAL CARE
Bringing a gentle touch to your smile

DATE: _____

PATIENT HISTORY UPDATE/ COVID-19 SCREENING

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S TEMPERATURE : ____

HAS THE ADDRESS/ PHONE # CHANGED SINCE YOUR LAST VISIT? ( ) YES ( ) NO

NEW ADRESS/ PHONE # _____

E-MAIL ADDRESS:_____

ANY MEDICAL CHANGES SINCE YOUR LAST VISIT? ( ) YES ( ) NO

_____

TAKING ANY MEDICATION? ( ) YES ( ) NO

_____

ALLERGIC TO ANY MEDICATIONS? ( ) YES ( ) NO

_____

FEVER/CHILLS	( ) YES ( ) NO	SORE THROAT	( ) YES ( ) NO
COUGH	( ) YES ( ) NO	HEADACHES	( ) YES ( ) NO
FATIGUE	( ) YES ( ) NO	NAUSEA/VOMITING	( ) YES ( ) NO
BODY OR MUSCLE ACHES	( ) YES ( ) NO	DIARRHEA	( ) YES ( ) NO
JOINT PAIN	( ) YES ( ) NO	NASAL CONGESTION	( ) YES ( ) NO
SHORTNESS OF BREATH	( ) YES ( ) NO	LOSS OF TASTE & OR SMELL	( ) YES ( ) NO

HAVE YOU BEEN IN CONTACT WITH ANYONE WITH COVID-19? ( ) YES ( ) NO

PLEASE NOTIFY OUR OFFICE OF ANY COVID-19 SYMPTOMS WITHIN 14 DAYS FROM YOUR APPOINTMENT

PATIENT/PARENT SIGNATURE _____

DOCTOR SIGNATURE _____

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Patient's Name: _____

INFORMED CONSENT
Dental 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 the flu, you may be exposed to COVID-19, also known as "Coronavirus," 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 favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. 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, dentist and dental staff.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes _____ Initial No _____ Initial

_____ _____
Patient /Responsible Party Signature Date

_____ _____
Staff Signature Date

_____ _____
Dr. Flores's Signature Date