# Monfredi Family Dental Pandemic Advisory/Acknowledgement

Dear Patient,

You have presented to the office today because you desire to have some dental care or treatment completed during the COVID-19 (Coronavirus) pandemic. Please be advised of the following:

- While our office complies with Ohio State Dental Board and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- Our entire staff are symptom free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

_____ **(Initials)** I will report to Monfredi Family Dental any signs or symptoms of COVID-19 that I develop in the next 14 days.

_____ **(Initials)** I have not had contact with anyone exhibiting the symptoms listed below or a COVID-19 positive individual, either in my home or in the community in the last 14 days.

**Please mark "Yes" or "No" to answer if you have had these 'symptoms' in the last 14 days or if you have ever been diagnosed with any of the 'conditions' listed below. If you do mark "Yes" to any of the below, we will ask relevant questions to learn additional information in order to keep you, our other patients, and our staff safe.**

| YES/NO - 'Symptoms' | YES/NO - 'Symptoms' | YES/NO - 'Conditions' |
|---|---|---|
| ___ ___ Fever (of 100.4 or higher) | ___ ___ Upset Stomach | ___ ___ Lung Disease |
| ___ ___ Shortness of Breath | ___ ___ Headache | ___ ___ Diabetes |
| ___ ___ Dry Cough | ___ ___ Fatigue | ___ ___ Auto-Immune Disease(s) |
| ___ ___ Runny Nose | ___ ___ Loss of taste or smell | ___ ___ Heart Disease |
| ___ ___ Sore Throat | | ___ ___ Kidney Disease |

**(YES) _____ / _____ (NO) - I have traveled outside of the state of Ohio in the last 14 days**

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist (Monfredi Family Dental) of any change in my health and/or physical symptoms related to COVID-19.*

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Signature of Responsible Party or Patient Date