Nakamura Children's Dentistry
Building Healthy Smiles

Patient Advisory and Acknowledgment Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient/Responsible Party:

Our goal is to provide a safe environment for our patients and staff. You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department 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 staff members are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, other persons (including other patients/guardians) could be infected, with or without their knowledge.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask during treatment as your health care providers need access to your mouth. This leaves you vulnerable to COVID-19 transmission while receiving treatment.

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.

Have you or your child been diagnosed positive for the COVID-19 virus at any time or are you currently awaiting the results of a COVID-19 test?				☐ Yes	☐ No
Have you or your child been in contact with any individual(s) that has tested positive for the COVID-19 virus or is currently awaiting the results of a COVID-19 test?				☐ Yes	☐ No
Has you or your child had any of the following?					
Fever	☐ Yes	☐ No	Runny nose	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Sore Throat	☐ Yes	☐ No
Dry cough	☐ Yes	☐ No	Loss of sense of tastes and/or smell	☐ Yes	☐ No
Headaches, fatigue, or weakness	☐ Yes	☐ No	Sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?	☐ Yes	☐ No
Have you travelled to any foreign country in the past 14 days?				☐ Yes	☐ No
Have you travelled within the US by commercial airline, bus or train within the past 14 days?				☐ Yes	☐ No
If so where?					

I confirm I have read the advisory and acknowledgement above and accept there is an increased risk of contracting COVID-19 in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge I could contract COVID-19 unrelated to my visit.

_____
Patient Name

_____ _____ _____
Parent/Guardian Signature Date Relationship to Patient