GWINNETT FAMILY
DENTAL CARE
Your Health, Your Smile, Our Commitment

COVID-19 PATIENT IN-OFFICE SCREENING FORM

This affidavit is required for all patients in compliance with guidelines from the American Dental Association

Patient's Name (print) _____

_____

COVID-19 Acknowledgement - ***Please acknowledge the following by initialing each statement below:***

_____ I am not over 60 years of age.

_____ I do not have a preexisting condition, such as lung disease, heart disease, diabetes, kidney disease, or an autoimmune disorder.

_____ I have not had any of the following symptoms within the past 14 days:

Fever	Cough
Shortness of breath or difficulty breathing	Chills
Repeated shaking with chills	Muscle pain
Headache	Sore throat
New loss of taste or smell	Trouble breathing
Persistent pain or pressure in the chest	New confusion or inability to awaken
Bluish lips or face	Symptoms of respiratory illness

_____ I have not been under the care or treatment of a healthcare provider for any of the above symptoms within the past 14 days.

_____ I have not been diagnosed with COVID-19 (Coronavirus).

_____ I have not been in contact with persons diagnosed with COVID-19 (Coronavirus).

_____ I have not been suspected of carrying the COVID-19 virus (Coronavirus).

_____ I have not been in contact with persons suspected of carrying the COVID-19 virus (Coronavirus).

_____ I am not currently under self-imposed, government, or hospital quarantine.

_____ I have not been under self-imposed, government, or hospital quarantine within the past 14 days.

_____ I consent to have my temperature taken via a non-contact infrared thermometer.

Signature of Patient or Parent/Guardian: _____ Date: _____