PATIENT ADVISORY AND ACKNOWLEDGEMENT

Dear Patient or Responsible Party,

You have come to our office for an 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 do not assure your safety., All of our stall and providers are fully vaccinated. Our 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.

Please only bring a child for an appointment if they are to be seen, please do not bring siblings along.

Wearing a mask is required for all common areas. Your provider may allow you to remove your mask in their office.

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.

Please check your responses below	**Adult**	**Child**
Have you had a COVID-19 Vaccine?	___yes ___no	___yes ___no
If so, date of final vaccine:	___/___/____	___/___/____
Are you fully vaccinated, 2 weeks past the 2nd . injection of the Moderna or Pfizer Vaccine, or 2 weeks past the Johnson & Johnson single dose?	___yes ___no	___yes ___no
Are you currently awaiting the results of a COVID-19 test?	___yes ___no	___yes ___no
Do you have a fever?	___yes ___no	___yes ___no
Do you have shortness of breath?	___yes ___no	___yes ___no
Do you have a dry cough, runny nose, or a sore throat?	___yes ___no	___yes ___no
Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?	___yes ___no	___yes ___no
Have you experienced headaches, fatigue, or weakness?	___yes ___no	___yes ___no
Have you lost your sense of taste and/or smell?	___yes ___no	___yes ___no
Do you have any other acute onset symptoms that are unusual?	___yes ___no	___yes ___no
Have you had contact with anyone who has COVID-19 diagnosed or who is in quarantine for exposure?	___yes ___no	___yes ___no

Patient/Responsible Party: _____ Date: _____

Relationship: _____

Name of Child patient if present: _____

Reviewed by: _____Date: _____