Liliana Cuervo DDS

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

Dear Parent/Guardian/Patient

You have come to our office today with your child 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 office staff is 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.

PLEASE ANSWER “YES” OR “NO” WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? _______ YES ________ NO

DO YOU HAVE A FEVER? _______ YES ________ NO

DO YOU HAVE ANY SHORTNESS OF BREATH? _______ YES ________ NO

DO YOU HAVE A DRY COUGH? _______ YES ________ NO

DO YOU HAVE A RUNNY NOSE? DO YOU HAVE A SORE THROAT? _______ YES ________ NO

DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? _______ YES ________ NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? _______ YES ________ NO

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? _______ YES ________ NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY? _______ YES ________ NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES? _______ YES ________ NO

IF SO, WHERE ____

______________________ ______________________________________ ____________

PATIENT NAME PARENT/GUARDIAN /PATIENT SIGNATURE DATE