Driftwood Dental
Committed to Dental Excellence

To be completed for both patient and ride, if applicable

COVID-19 Wellness Assessment Form - ENTIRE HOUSEHOLD

Date: _____ PtName: _____

Ride/Parent Name/#: _____

Procedure: _____ Readings Temp: _____ O2: _____

Contact #: _____

Phone Screening:

IN THE PAST 14 DAYS…

Test Positive? Y / N If Y, When: _____

Informed of exposure /Contact Traced? Y / N

Advised to self Isolate? Y / N If so, until when? _____

Symptoms in the past 14 days: If so, when/where? _____

Fever?	Y / N	Difficulty Breathing?	Y / N
Chills?	Y / N	Extreme Fatigue?	Y / N
Dry Cough?	Y / N	Loss of Smell/taste?	Y / N
Sore Throat?	Y / N	Loss of Appetite?	Y / N
Body aches?	Y / N	Nausea/Vomiting/Diarrhea?	Y / N
Headaches?	Y / N		

IF YES TO ANY OF THE ABOVE QUESTIONS (IF NO SEASONAL ALLERGIES) IN-CLINIC TREATMENT MUST BE REFERRED TO HOSPITAL SETTING

Seasonal Allergies? Y / N Allergies: _____

Medical Allergies? Y / N Allergies: _____

IF ELIGIBLE FOR IN-CLINIC TREATMENT

Reconfirm:

Phone Screening?	Y / N	Hand Sanitizer/Washing?	Y / N
Covid Test?	Y / N N / P	Consent forms?	Y / N
Temp reading (Max 37.5):	_____	Pulse Oximeter (Assess at 93%)	_____

Consent Form During Pandemic

The best available scientific evidence is that COVID-19 is transmitted through the release of droplets into the air onto surfaces, including by sneezing or coughing. We encourage all patients who have questions about the safety of dentistry during COVID19 to address them with their dental care provider. Certain dental procedures create water spray which may contribute to the risk of transmission. At this time, dental practices will attempt to limit treatment to procedures that do not produce spray (aerosol) whenever possible. This may mean that a temporary solution or modified treatment approach may be required. Sometimes it is not possible to eliminate aerosols.

While much about COVID19 still remains unknown, there may be a risk of contracting the virus in a dental office.

Acknowledgement and Consent

- I have received information about COVID-19 .
- I acknowledge that I have informed the dental practice if I have ANY of these symptoms or risk factors.
- I accept the risks of transmission of the virus in a dental office setting.
- I understand that dental treatment options may be limited during this time in an effort to reduce/eliminate the risk of transmission.
- I have had an opportunity to ask questions and have had my questions answered to my satisfaction.
- I consent to and wish to proceed with dental treatment.

Patient Signature: _____

Printed Name:_____ Date: _____