Health Declaration Form-COVID-19

While we try our best to provide you with treatment you need, we need you to be forthcoming with us with any history/ information with regarding to COVID-19 in order for us to protect you, other patients and our staff.

Print Name (Last name, first name):

Date of Birth (ddmmyy):

Yes	No	COVID-19 screening questions
		1. In the past 14 days, have you or any household member traveled internationally (China, Iran, Italy, Japan, South Korea, and any European country) or anywhere in the world?
		2. In the past 14 days, have you or any household member had any contact with a COVID-19 patient or people with COVID-19 alike symptoms?
		3. Have you or any household member have a history of exposure to COVID-19 biologic material?
		4. Have you or any household member show any symptoms of COVID-19 (fever, cough, shortness of breath…etc) in the past 14 days?
		5. URGENT DENTAL NEED QUESTION Do you have uncontrolled dental or oral pain, infection, swelling or bleeding or trauma to your mouth?

In signing below, I, an individual over the age of 18 of sound mind, knowingly, voluntarily, and freely agree to this Declaration, and in doing so represent the truthfulness and veracity of the above answers.

_____ _____

Signature Date