PATIENT NAME: _____

Cook & Gutsche
ORTHODONTICS
We Make Your Smile

**PATIENT ADVISORY AND ACKNOWLEDGEMENT**
**For Receiving Orthodontic Treatment During the COVID-19 Pandemic**

You have come to our office today for routine orthodontic treatment or an evaluation that will be performed during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with or exceeds Pennsylvania Department of Health 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 that you will not be exposed to COVID-19.
- 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.

In order to reduce the risk of spreading COVID-19, please answer the screening questions below.

**PLEASE ANSWER THE FOLLOWING QUESTIONS "YES" OR "NO"**
**For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.**

Have you been diagnosed positive for COVID-19 at any time? Yes_____ No_____
If yes, date of diagnosis:

Are you currently awaiting the results of a COVID-19 test? Yes_____ No_____

Have you been in contact with anyone who has tested positive for COVID-19, or has symptoms consistent with COVID-19, in the last 14 days? Yes_____ No_____

Do you have a fever or chills? Yes_____ No_____

Do you have any shortness of breath? Yes_____ No_____

Do you have a dry cough? Yes_____ No_____

Do you have a sore throat? Yes_____ No_____

Do you have congestion, a runny nose, sneezing, and/or sinus pain or pressure that is unusual and not related to seasonal allergies? Yes_____ No_____

Are you experiencing fatigue? Yes_____ No_____

Have you lost your sense of taste and/or smell? Yes_____ No_____

Are you experiencing nausea, vomiting, or diarrhea? Yes_____ No_____

Have you travelled outside of Pennsylvania within the last 14 days? Yes_____ No_____
If yes, where:

I understand the COVID-19 exposure risks associated with orthodontic treatment, and attest that I have answered the above questions truthfully.

Signature of patient/responsible party:_____ Date:_____