Patient Name (Print Legibly) ____

Date of Birth: _______________

Cell Phone#: __________________________ Insurance changes to report? Yes____ No_____

If yes, please indicate what insurance changes have occurred:

____

	Yes	**No**
Do you have COVID symptoms?	☐	☐
Have you tested positive for COVID in the last 10 days?	☐	☐
Have you been tested for COVID and are awaiting results?	☐	☐

Patient Consent

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19 at any time or in any place. Be assured that we continue to follow state and federal regulations as well as recommended universal personal protective equipment (PPE) and disinfection protocols to limit transmission of all diseases in our office.

Despite our careful attention to sterilization, disinfection, and the use of personal barriers, you may be exposed to an illness in our office, just as you might be exposed elsewhere.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes________ No_________

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Patient Signature (or Parent/Guardian if Minor) ____________________________________

Date____________________