SUNRISE DENTAL SERVICE

www.SunriseDentalService.com
(631) 567-5566

Dr. A. Makadia, D.D.S.
1604 Lakeland Avenue
Bohemia, NY 11716

Patient Screening Form

Patient Name: **Date:**

Have you received the COVID-19 vaccination?	☐YES	☐NO
If you answered yes to the above question, what was the date of your vaccination?	**Month/Year:**	
Are you currently experiencing, or have you recently (within the past 48 hours) experienced ANY of the following symptoms of COVID-19? - Cough (new or worsening) - Shortness of breath (new or worsening) - Trouble breathing (new or worsening) - Fever (above 100.4 degrees Fahrenheit) - Chills - Muscle pain or body aches (new or worsening) - Headache (new or worsening) - Sore throat (new or worsening) - New loss of taste or smell - Fatigue - Congestion or runny nose - Nausea or vomiting - Diarrhea	☐YES	☐NO
Have you had any known close contact with a person confirmed (by diagnostic test) or suspected (based on symptoms) to have COVID-19 in the past 10 days?	☐YES	☐NO
Have you tested positive for COVID-19 through diagnostic test in the past 10 days?	☐YES	☐NO
Have you travelled internationally or within a U.S. state or territory that does not border New York for longer than 24 hours within the past 10 days and failed to follow the states travel advisory?	☐YES	☐NO

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Dental Treatment Consent and Affirmation Form

1. I knowingly and willingly consent to dental treatment at Sunrise Dental Service by Dr. Makadia and any designated associates or employees during COVID-19.
2. I understand that COVID-19 has a long incubation period and during which carriers of the virus may not show symptoms but are still highly contagious. It is impossible to determine who has COVID-19 and who does not, given the current limitations and availability of COVID-19 viral testing.
3. Risk of transmission: I understand that due to the frequency of visits of other dental patients under care, characteristics of the virus, and characteristics of dental procedures, that I have risk of contracting the virus simply by being in the dental office, even though standard precautions are being observed.
4. I am unaware of being a possible carrier or infected: I confirm that I have not been tested positive for COVID-19 in the last 30 days and information provided on page 1 of the patient screening form is correct.
5. Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less) with someone who has tested positive for COVID-19 in the last 10 days or anyone who has had the symptoms stated on page 1 of the patient screening form.
6. Public travel: I confirm that I have not travelled outside of the Unite States in the past 10 days. I confirm that I have not travelled domestically by commercial airline, bus, or train within the last 10 days.
7. INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 or infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, that may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental treatments recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions OR decline the procedure.

I acknowledge that I have read and understand these statements.

Patient Name: _____

Patient Signature: _____ Date: _____