SPORTING SMILES
Pediatric Dentistry & Family Orthodontics
7915 Lake Manassas Drive • Gainesville, VA 20155 • Suite 301 • 703-743-5937

COVID-19 Pandemic Dental Treatment Advisory and Acknowledgment Form

You have presented to the office today for dental treatment. While our office complies with the State Health Department and Centers for Disease Control and Prevention infection control guidelines to prevent the spread of COVID-19, we cannot make any guarantees. The COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. Our team members 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 the virus, we have asked you several screening questions below. For the safety of our staff, other patients, and yourself, please be truthful in your answers.

Please answer 'Yes' or 'No' by circling the appropriate answer to the following questions:

Do you, or anyone in your household, have/or have you recently had:

Fever?	Yes	No
Shortness of breath?	Yes	No
Dry cough?	Yes	No
Any other flu-like symptoms?	Yes	No
Have you experienced recent loss of taste or smell?	Yes	No
Have you, or anyone in your household, had contact with any confirmed COVID-19 positive people?	Yes	No
Within the last 14 days:		
Have you travelled outside of the US?	Yes	No
Have you travelled within the US?	Yes	No

If so, where?

_____

I have been made aware of the CDC and ADA guidelines that under the current pandemic all non-essential dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. I confirm the dental treatment I am seeking for myself/my child(ren) meets this criteria. _____ (Initial)

Patient Name (Print) _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____

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