SMILECREATOR of Bingham Farms℠

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COVID-19 Patient Safety Screening and Consent

Due to the recent outbreak of COVID-19, the office of Dr. Timothy Kosinski has implemented several safeguards that abide by local, state, and federal regulations to ensure your safety and the safety of others. This consent is to be used as a screening tool for infection prevention and control.

Patient Name: _____ **D.O.B:**_____

Temp: _____

1. Are you COVID-19 Vaccinated? ❒ Yes ❒ No
2. Have you had the COVID-19 infection? ❒ Yes ❒ No
   If yes, when?_____ Hospitalized? ❒ Yes ❒ No
3. Have you recently experienced any of the following symptoms (please check):
   ❒ Fever
   ❒ Shortness of breath
   ❒ Complete loss of taste or smell
   ❒ Cough
   ❒ Extreme fatigue
   ❒ Sore throat
   ❒ Nausea, vomiting, diarrhea
   ❒ None of the above
4. Have you recently been in direct contact (interaction less than 6 ft distance AND interaction greater than 15 minutes within a 24 hour period WITH or WITHOUT a mask) with anyone with a confirmed positive COVID-19 test?
   ❒ Yes ❒ No
5. Have you recently been in direct contact with anyone who is being tested or has a pending COVID-19 test?
   ❒ Yes ❒ No
6. Have you recently been tested for COVID-19 or are awaiting results?
   ❒ Yes ❒ No

I have answered these questions honestly and to the best of my knowledge. Dental procedures can create water spray; the ultra-fine nature of the spray can linger in the air for minutes to hours, which can transmit the virus. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand that by entering the practice, I may be in close contact with individuals, therefore, I may have an inadvertently increased risk for exposure. I will comply with all regulations to ensure the safety of others as well as myself.

Patient Signature _____ Date:_____

Witness:_____