Dear Patient,

You have presented to the office today because you have an urgent medical condition which must be treated at this time and cannot be postponed until the current COVID-19 risk period abates. Please be advised of the following:

While our office complies with the State Health Dept & CDC and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. 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 accommodations, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, this questionnaire must be completed prior to your treatment today. For the safety of our staff, and yourself, please be truthful and candid in your answers. **PLEASE ANSWER "YES"OR "NO"WITH YOUR INITIALS TO THE FOLLOWING QUESTIONS**:

1. Have you taken a COVID test and awaiting test results? ____Yes ____No
2. Do you have a fever (temperature over 100.4 F or 38 C (Without having taken any fever-reducing medications?) ____Yes ____No
3. Do you have a loss of smell or taste? ____Yes ____No
4. Do you have a cough? ____Yes ____No
5. Do you have a muscle ache? ____Yes ____No
6. Do you have a sore throat? ____Yes ____No
7. Do you have congestion or a runny nose? ____Yes ____No
8. Do you have shortness of breath? ____Yes ____No
9. Do you have chills? ____Yes ____No
10. Do you have a headache? ____Yes ____No
11. Have you experienced any new gastrointestinal symptoms such as nausea, vomiting, diarrhea, or loss of appetite in the last few days? ____Yes ____No
12. Have you, or anyone you have been in close contact with, been diagnosed with COVID-19 or placed in quarantine for possible exposure to COVID-19 within the last two weeks? ____Yes ____No
13. Have you been asked to self-isolate or quarantine by a medical professional or a local public health official last two weeks? ____Yes ____No
14. Have you travelled within the U.S. or any foreign country Within the last 14 days? ____Yes ____No

Patient Name: _____ Signature: _____

Date: _____