Patient Information

First Name ❋

Characters: (500 max.)

Last Name ❋

Characters: (500 max.)

Phone Number ❋

Characters: (500 max.)

Birth Date (MM-DD-YYYY) ❋

Characters: (500 max.)

Health Questionnnaire

Have you, your child, or others accompanying you to today's appointment or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease? ❋

- ☐ Yes
- ☐ No

If yes, when?

Characters: (500 max.)

Do you, your child, or others accompanying you to today's appointments or other recent acquantainces have any of the following:

A Fever (defined as above 100.4 degrees)? ❋

- ☐ Yes
- ☐ No

A Cough? ❋

- [ ] Yes
- [ ] No

Shortness of Breath and/or Trouble Breathing? ❋

- [ ] Yes
- [ ] No

Persistent Pain, Pressure, or Tightness in the Chest? ❋

- [ ] Yes
- [ ] No

I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's orthodontic appointment. ❋

- ◯ Yes Clear

I understand that I will be required to wear a mask while in the orthodontic office. ❋

- ◯ Yes Clear

Date ❋

mm/dd/yyyy