

RUSSO PERIODONTICS

John Russo, DDS, MHS
Specialist in Periodontics

Informed Consent/Questionnaire Communicable Diseases

With Community transmission of communicable diseases, you could be exposed anywhere to infectious diseases including, but not limited to Covid-19 (also called Coronavirus). Our dental office is following the State and Federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of communicable diseases. However, it is possible that these precautions will not always be successful in blocking the transmission of these diseases. Social distancing nationwide has reduced the transmission of Covid-19, however it is not possible to provide dental treatment with social distancing between the patient, dentist, dental staff and sometime, other patients. By presenting yourself or your child for dental treatment, you assume and accept the risk that you or your child may inadvertently be exposed to a communicable disease. If you have been exposed to a communicable disease prior to your dental appointment, you may spread the disease to the dentist, dental staff and to other patients/parents in the practice. Therefore, prior to each appointment, we require you to answer the following questions:

Have you, your child, or others accompanying you to today's appointment been **tested positive** for or been diagnosed as having Covid-19?

Yes _____ No _____ If so, when? Date _____

Temperature _____ C or F Date _____ Staff Initials _____

Cough? Yes _____ No _____

Shortness of breath and/or trouble breathing? Yes _____ No _____

Diarrhea of recent onset? Yes _____ No _____

Pinkeye (conjunctivitis) Yes _____ No _____

Persistent pain, pressure or tightness in the chest? Yes _____ No _____

If you have had any of these symptoms or have recently tested positive for or been diagnosed with Covid -19, you will be asked to reschedule your dental appointment. Do you acknowledge and accept the risk of exposure in our dental office to a communicable disease, included but not limited to Covid – 19, and consent to treatment? Yes _____ NO _____

Signature _____ Date _____