

SUPPLEMENTAL HEALTH QUESTIONNAIRE

Orthodontic Treatment in the Era of COVID-19

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Do you, your child, others accompanying you today or anyone else you have recently been in contact with have any of the following symptoms?

- | | | |
|----------------------------------------------------------------------|------------------------------|-----------------------------|
| • Fever (defined as above 100.4° F degrees)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Chills? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Cough? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Sore Throat? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Shortness of breath and/or trouble breathing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Persistent muscle pain, pressure or tightness in the chest? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • New loss of taste or smell? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you or others accompanying you to today's appointment traveled outside of our local area or outside of the US within the past 14 days?

Yes No

Have you, your child, others accompanying you today or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease?

Yes No

If yes provide approximate dates of illness _____ through _____
symptom start date symptom end date

I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's orthodontic appointment to a later date.

Patient Name

Parent/Guardian Name (if applicable)

Relation

Patient/Parent/Guardian Signature

Date



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