Patrick M.Ohlenforst, D.D.S., M.S., Inc.

PATIENT HEALTH QUESTIONNAIRE & INFORMED CONSENT

Orthodontic Treatment in the Era of COVID-19

Thank you for your trust in our practice. We have missed each of you and are excited to continue taking care of you!

As with transmission of any communicable disease such as the common cold or flu, you may be exposed to COVID-19 (sometimes called "Coronavirus") at any time or in any public place. If you have been exposed to a communicable disease, you could spread it to the orthodontist, orthodontic staff, or other patients or parents. To help protect those entering our practice space, we ask that you complete the questionnaire below prior to coming in for your appointment. If you answer "yes" to any of the following, we may ask you to reschedule your appointment for the safety of our staff and other patients.

QUESTIONNAIRE: **Have you or anyone who lives in your household, at any time in the last 14 days:**

1. Been in contact with someone who in the last 14 days tested positive for COVID-19? Yes ___ No ___
2. Tested positive for COVID-19? Yes ___ No ___
3. Submitted to a test for COVID-19? Yes ___ No ___
4. Had a fever? (defined as above 99.6 degrees)? Yes ___ No ___
5. Had any shortness of breath and/or trouble breathing? Yes ___ No ___
6. Had persistent pain, pressure or tightness in your chest Yes ___ No ___
7. Had a cough or sore throat? Yes ___ No ___
8. Travelled outside of the DFW area? Yes ___ No ___

   If so, where? _____

INFORMED CONSENT: We are committed to compliance with all applicable health regulations and we routinely monitor applicable guidelines, including ones from the American Association of Orthodontists. Even with our careful attention to sterilization, disinfection, and use of personal barriers, and social distancing when possible, there is still a chance that you could be exposed to an illness in our office. For example, due to nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff, and sometimes other patients, at all time. By signing below, you acknowledge we have provided you this information to allow you to make an informed consent to treatment at our office, and you confirm that you have answered questions 1 – 8, above, truthfully and to the best of your knowledge, and you consent to treatment.

Agreed to by or on behalf of Patient: _____(Patient Name)

Signature: _____ Date: _____

Printed Name: _____ [ ] Patient / [ ] Parent / [ ] Guardian