Today's Date: _________________

COVID-19 Supplemental Consent

Patient Name:_______________________________ Date Of Birth: ______________________

Please review the following and INITIAL all that apply:

_____ Patient/ Guardian has had any of the following Symptoms within past 14 days: Fever, Cough, Shortness of Breath OR has been around a person with these symptoms.

_____ Patient/ Guardian has traveled within past 14 days OR been around someone that has traveled within past 14 days. If yes, Where to: ____

_____ Patient/ Guardian has been confirmed or is currently under testing for COVID-19 or been around any person who has.

_____ None of the above apply to Patient/Guardian

I, ______________________, certify that above statements initialed are true to the best of my knowledge. I understand that any false information given could be dangerous to me, my child and/or others around me. I am aware of the State of National Emergency that the United States is in with regards to COVID-19. I recognize there is a risk of exposure to COVID-19 to myself and my child (if patient is a minor) when not isolated from other people.

I accept all risks associated with being seen during this crisis and opt to be seen by Healthy Smiles on this date.

____
Printed Name of Person Signing Document

____ ____________________
Patient/ Guardian Signature Date