VINCENT TEAM orthodontics

SUPPLEMENTAL HEALTH QUESTIONNAIRE

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:

Has the patient or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease? No ☐ Yes ☐ If yes? Date _____

Does the patient other recent acquaintances have:

- A Fever (defined as above 99.6 degrees)? No ☐ Yes ☐
- A Cough? No ☐ Yes ☐
- Shortness of Breath and/or Trouble Breathing? No ☐ Yes ☐
- Persistent Pain, Pressure, or Tightness in the Chest? No ☐ Yes ☐

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

Patient's name _____

Patient/Parent's Signature _____ Date _____

SUPPLEMENTAL INFORMED CONSENT – COVID 19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the 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 times.

Although exposure is unlikely, do you accept the risk and consent to treatment? No ☐ Yes ☐

Patient/Parent's Signature _____ Date _____