

## **COVID-19/Coronavirus Patient Notice and Acknowledgement Form**

As you are aware, the Centers for Disease Control and Prevention has issued warnings and precautions to health care providers worldwide regarding coronavirus and COVID-19.

Here at **Joel D. Singer, DMD** we are taking every precaution to limit the exposure to any virus within our office community and we ask that you participate in the taking these precautions.

Please inform us immediately if you are currently experiencing a fever, cough, or difficulty breathing. By the placing of your initials here, you attest that you do not currently have a fever, cough, or difficulty breathing. (initial)\_\_\_\_\_

Please inform us immediately if you have traveled outside of the United States within the past thirty (30) days. By the placing of your initials here, you attest that you have not traveled outside the United States within the past thirty (30) days. (initial)\_\_\_\_\_

Please inform us immediately if you have had any recent travel outside of the state of **New Jersey**. By the placing of your initials here, you attest that you have not traveled outside the state of **New Jersey** within the past thirty (30) days. (initial)\_\_\_\_\_

If you have traveled outside of this state, please list the places to which you have traveled in the last thirty days, please list the places to which you have traveled.

(list)\_\_\_\_\_

Please inform us if you have had any contact or other exposure to a person diagnosed with, or subsequently diagnosed with, COVID-19. By the placing of your initials here, you attest that you have not had any contact or other exposure to a person diagnosed with, or subsequently diagnosed, with COVID-19. (initial)\_\_\_\_\_

In our efforts to protect the safety of the practice community as well as the community at large, it is the policy of **Joel D. Singer, DMD** to reschedule a patient's appointment for elective care if the patient is exhibiting symptoms of COVID-19, recently traveled abroad or to a high risk area, or was subject to a known exposure event.

In placing your signature below, you attest to the truth of your answers above and your understanding of **Joel D. Singer, DMD** office policy. We thank you and look forward to a return to normal practice.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Legal Guardian