SOUTH SHORE ORAL SURGERY ASSOCIATES

DR. STEVEN J. VERVENIOTIS | DR. RICHARD M. MIRRA

PATIENT INFORMATION

First Name		Last Name		Birth Date	

COVID-19 ACKNOWLEDGEMENT OF RISK AND HEALTH SCREENING FORM

Our practice wants to ensure you are aware of the relative risks of exposure to COVID-19 associated with receiving treatment. This practice has always followed the applicable state and federal regulations and recommendations regarding infection control, sterilization, disinfection, and the use of PPE (personal protective equipment). We also work to protect our patients and office staff from virus spread by promoting frequent hand washing and office cleaning, using PPE for patient encounters, and adding additional environmental controls in the treatment areas.

Although we are using enhanced infection control measures in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing during treatment or for you to wear a mask during treatment. This means that the risk of exposure to COVID-19 remains when receiving treatment during the pandemic.

COVID Health History		
Have you ever been diagnosed with COVID-19?	❑ Yes	❑ No
If yes, when?		
Have you ever been hospitalized for COVID-19 treatment?	❑ Yes	❑ No
If yes, when?		
Are you fully vaccinated or in the course of being vaccinated for COVID-19?	❑ Yes	❑ No
Have you been tested for COVID-19 and are awaiting results?	❑ Yes	❑ No
In the last 14 days, have you been in contact with any confirmed cases of COVID-19?	❑ Yes	❑ No
Symptoms – Today, or in the last 14 days		
Have you had a fever or felt hot or feverish?	❑ Yes	❑ No
Have you had any shortness of breath or other breathing difficulties?	❑ Yes	❑ No
Have you had a cough?	❑ Yes	❑ No
Have you had any other flu-like symptoms, such as an upset stomach, headache, or fatigue?	❑ Yes	❑ No
Have you had a loss of taste of smell?	❑ Yes	❑ No
Have you otherwise felt unwell?	❑ Yes	❑ No

PATIENT ACKNOWLEDGMENT

By signing this document, I acknowledge that I have read the Patient Acknowledgment and that I understand and accept that there is a risk of COVID-19 exposure with treatment. I also acknowledge that the Health History Screening answers I have provided are true and accurate.

Signature of Patient, Parent or Legal Guardian		Date	

IF PATIENT IS A MINOR

Printed Name		Relationship to Patient	