



## HEALTH QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Patient Temp \_\_\_\_\_  
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Patient Name: \_\_\_\_\_ Patient Temp \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Patient Temp \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Parent Temp \_\_\_\_\_

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**Do you, the patient, or anyone in your household currently have any of the following symptoms?**

Fever of 100 or Higher	Y/N	Muscle/Joint Pain	Y/N
Shortness of Breath	Y/N	Sputum Production	Y/N
Dry Cough	Y/N	Sore Throat	Y/N
Flu-Like Symptoms	Y/N	Vomiting, Diarrhea, Stomach Pain	Y/N
Fatigue	Y/N		

If you or the patient(s) are **not** fully vaccinated against COVID-19:

**Have you or the patient(s) been in direct contact with someone diagnosed with COVID-19, or someone who has exhibited any of the symptoms listed above, in the past 10 days?** Yes \_\_\_ No \_\_\_

**Have you or the patient(s) or any member of your household and/or the patient's household been diagnosed with COVID-19 within the last 10 days?** Yes \_\_\_ No \_\_\_

**Travel Questionnaire:**

As of May 17, 2021, New Jersey's travel advisory is no longer in effect.

New Jersey residents returning home and travelers visiting New Jersey do not need to quarantine, but should follow travel guidance from the CDC, the NJ Department of Health, and all local health and safety protocols of their travel destination.

**At this time, the CDC recommends delaying travel until you are fully vaccinated. The CDC currently also recommends that unvaccinated individuals get tested 1-3 days before their trip, 3-5 days after travel, and stay home and self-quarantine for 7 days after travel.**

Are you and the patient(s) in compliance with the CDC recommendations noted above in **BOLD**?  
Yes \_\_\_ No \_\_\_ If no, **please inform our Front Desk immediately.**

**I hereby certify that the statements above are true:**

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date



PATIENT REQUEST FOR TREATMENT  
INFORMED CONSENT

I acknowledge and understand that there is an increased risk that COVID19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office and the patients, staff and other individuals who enter the premises.

Accordingly, as a precondition to rendering treatment to myself as the patient, or my child as the patient, I have confirmed that:

- I/we have no symptoms associated with COVID19, including fever, shortness of breath, dry cough, running nose or sore throat.
- I/we have followed the below CDC and NJ DOH recommendations:

**As of May 17, 2021, New Jersey's travel advisory is no longer in effect.** New Jersey residents returning home and travelers visiting New Jersey do not need to quarantine, but should follow travel guidance from the CDC, the NJ Department of Health, and all local health and safety protocols of their travel destination.

**At this time, the CDC recommends delaying travel until you are fully vaccinated. The CDC currently also recommends that unvaccinated individuals get tested 1-3 days before their trip, 3-5 days after travel, and stay home and self-quarantine for 7 days after travel.**

- For those that are not fully vaccinated, I/we have not within the past 10 days, been in close proximity (less than 6 feet) at non-compliant large gatherings, or had close contact with a person who has confirmed positive for COVID19 or is presumptive positive for COVID19.

I hereby consent to the treatment proposed by the dentist for myself as the patient, or for my child as the patient.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_