Dr. Kim Bradford D.D.S., P.C & Dr. Monica L. Lewis D.D.S., P.C

COVID-19/Coronavirus Patient Notice and Acknowledgement Form

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

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

Please inform us immediately if you are currently experiencing a fever, cough, difficulty breathing, or loss of sense of taste and/or smell. By placing your initials here, you attest that you do not currently have fever, cough, difficulty breathing, or loss of sense of taste and/or smell.

(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 travel outside the state of **Michigan**. By the placing of your initials here, you attest that you have not traveled outside the state of **Michigan** within the past thirty (30) days.

(initial)_____

If you have traveled outside of this state please list the places in 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 any other exposure to a person diagnosed with or subsequently diagnosed with, COVID-19. By placing 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 our office to reschedule a patient's appointment for elective care if 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 our office policy. We thank you for your cooperation.

_____ _____

Print Name Date

_____

Signature of Patient or Legal Guardian