CARE & CURE DENTAL

SCREENING / DISCLOSURE FORM FOR DENTAL PATIENTS DURING COVID-19 PANDEMIC

Name of Patient: **Age:**

Mobile:

	Covid-19 Questionnaire *(all questions must be answered)*	Yes / No
1	Do you have symptoms of Fever, Cough, Sneezing, Sore throat, fatigue and myalgia (body ache)? तुम्हाला सर्दी , खोकला, शिंका येणे , ताप , घसा दुखणे , अंग दुखणे , थकवा जाणवणे ह्या पैकी काहीही होत आहे का ?	
2	Do you have Difficulty in breathing? तुम्हाला श्वास घेताना त्रास होत आहे का ?	
3	Do you feel loss of taste or smell sensation? तुमच्या तोंडाची चव गेली आहे का?	
4	Did you have vomiting or diarrhoea in last 15 days? गेल्या १५ दिवसात दिवसात तुम्हाला उलटी किंवा जुलाब झालेले आहेत का?	
5	Exposure to a confirmed Covid - 19 case OR to Suspicious patient in the last two weeks? गेल्या १५ दिवसात कोविड -१९ सनक्रमित किंवा संशयी व्यक्ती शी संपर्क आला आहे का ?	
6	Have you ever been tested for Covid-19? तुमची covid -१९ ची चाचणी (टेस्ट) झाली आहे का ? Date of testing: Result:	
7	Have you been vaccinated for COVID-19? तुमचे covid -१९ चे लसीकरण झाले आहे का ? Date of latest vaccination/ लसीकरणाची तारीख :	

The above information given by me is true to the best of my knowledge. I fully understand and acknowledge that withholding or misrepresentation of any information is highly unethical and against the interest of larger population during this pandemic.

I have been made aware that dental procedures create ultra-fine water spray that may transmit the Covid-19 virus. I understand the Covid-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. I also understand that, due to the contagious nature of the disease and characteristics of dental procedures, I have an increased risk of contracting the virus simply by being in a dental office in spite of the best disinfection protocols applied.

I fully understand and acknowledge that I may be an asymptomatic carrier of the disease and hence will strictly comply with all the safety precautions and protocols advised. In the eventuality of my testing Covid-positive at a later date, I will not hold the dental service provider/staff/set-up responsible for it. I hereby knowingly and willingly give consent to have my emergency / urgent dental treatment done during the Covid pandemic.

Date: : **Patient Signature:**