HOPMEADOW DENTAL LLC

714 Hopmeadow Street, Suite 2

Simsbury, CT 06070

AAOIC Supplemental Health Questionnaire

First Name: ___________________________________

Last Name: ___________________________________

Middle Initial: _________

DOB: ________________

If you have been exposed to a communicable disease, you may risk spreading the disease to other patients and office staff. To protect our patients and staff, and in the interest of reducing the chance of transmission, prior to each appointment, we ask that you answer the following questions:

Please answer these questions within 24 hours prior to your appointment

Have you, your child, recent acquaintances, or others accompanying you today tested positive for or been diagnosed as having COVID-19, or any other communicable disease?

No Yes If so, when? (Date): ______________________

Do you, your child, others accompanying you to today's appointment, or recent acquaintances have:

* A fever? (defined as above 99.6 degrees): No Yes

* A cough? No Yes

* Shortness of breath and/or trouble breathing? No Yes

* Persistent pain, pressure or tightness in the chest? No Yes

By signing, I also understand that if the answer to any of these questions is yes, I may be asked to reschedule my dental appointment:

Patient/Parent or Guardian Signature: Date:

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