ANDERSON ORTHODONTICS

WELLNESS SCREENING FORM

This form must be **completed** on the day of the appointment and **signed** by a patient (18 years or older) or parent/guardian of the patient.

Incomplete or unsigned forms will result in rescheduling of the appointment.

If you have been exposed to a communicable disease, you may spread the disease to the orthodontist, orthodontic staff, or other patients/parents in the office.

Therefore, prior to each appointment, we will be asking the following questions to reduce chances of transmission.

1. **Have you, your child, or others accompanying you to today's appointment or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease?**

   ☐ Yes *Date diagnosed* ____/_____/_____
   ☐ No

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

   ☐ Yes ☐ No ----- Fever *(defined as above 99.6 degrees)*
   ☐ Yes ☐ No ----- Cough
   ☐ Yes ☐ No ----- Shortness of breath and/or trouble breathing
   ☐ Yes ☐ No ----- Persistent pain, pressure, or tightness in the chest

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I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's orthodontic appointment.

_____ _____/_____/_____
Patient Name ***Birthdate***

_____ _____
Patient/Guardian Signature **Date**

_____ _____
Relationship Email address