Orthodontic Solutions
for Children & Adults

American Association of Orthodontics
Supplemental Health Questionnaire

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

Patient Last Name _____ Patient First Name _____

Mobile phone number _____ Address _____

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 ____ No ____
   If yes, when and please elaborate: _____
2. Have you, your child, or others accompanying you to today's appointment or other recent acquaintances have a fever (defined as above 99.6 degrees F)? Yes ____ No ____
   If yes, when: _____
3. Have you, your child, or others accompanying you to today's appointment or other recent acquaintances have a persistent cough? Yes ____ No ____
4. Have you, your child, or others accompanying you to today's appointment or other recent acquaintances have shortness of breath or trouble breathing? Yes ____ No ____
5. Have you, your child, or others accompanying you to today's appointment or other recent acquaintances persistent pain or tightness in the chest? Yes ____ No ____
6. Have you, your child, or others accompanying you to today's appointment or other recent acquaintances traveled to a national or international location that is deemed high risk for COVID-19?
   Yes ____ No ____

I understand that if I answer "yes" to any of these questions that I will be asked to reschedule today's orthodontic appointment. The office will follow-up with you to determine the best time to reschedule the appointment.

Please print name of patient or guardian who is filling out this form: _____
Print Name

To the best of my knowledge, I confirm that the above information is accurate. _____
Signature Date

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Supplemental Informed Consent

for Orthodontic Treatment During COVID-19 Era

Patient Last Name | Patient First Name

Mobile phone number | Address

Thank you for your trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to SARS-CoV-2 (the virus that is commonly referred to as coronavirus and that causes Covid-19), at any time or in any place. Be assured that we have always followed state and federal regulations and all recommended universal personal protection and disinfection protocols to minimize the risk and limit transmission of all diseases in our office and we will continue to do so.

Despite our careful attention to sterilization, disinfection and the use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store or favorite restaurant. Social distancing nationwide has reduced the transmission of the coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures that we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure to coronavirus or other communicable diseases in our office is very unlikely with all of the precautions that we take, the risk cannot be reduced to zero. Do you accept the risk and consent to treatment?

Yes ____ No ____

Please print name of patient or guardian who is filling out this form:_____
Print Name

To the best of my knowledge, I confirm that the above information is accurate. _____
Signature Date