COVID-19 PRE-SCREENING & DISCLOSURE/CONSENT

1. Have you OR anyone you are in close contact with been diagnosed or is being monitored for COVID-19 in the last 30 days?

   No Yes

2. Are you OR anyone you are in close contact with currently experiencing any of the following symptoms?

Cough	No	Yes
Sore Throat	No	Yes
Fever (greater than 38ºF or 100.4ºF)	No	Yes
Muscle pain	No	Yes
Weakness	No	Yes
Diarrhea/Vomiting/Abdominal Pain	No	Yes
Difficulty breathing/Shortness of breath	No	Yes

Current studies indicate that some dental procedures create aerosolized particles (similar to a sneeze) of the virus that causes COVID-19, which can linger in the air for minutes to sometimes hours. This can result in the transmission of COVID-19 (Coronavirus) from an infected person. I fully understand that proceeding with the treatment today may increase my exposure/my child's exposure and therefore my risk of contracting community acquired COVID-19 (Coronavirus) infection.

Patient Name ____________________ Guardian/Visitor Name ____________________

Signature of Patient or Guardian/Visitor ____________________ Date ____________________

FROM THE HOUSE ON THE HILL
400 S 38th Ct, Ste A, Renton, WA 98055 / hello@evergrins.com / 425-255-6008
Mon-Thu 7:00 am – 4:30 pm / Fri-Sun CLOSED