

Supplemental Health Questionnaire

Orthodontic Treatment in the Era of COVID-19

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 reduce the chances of transmission:

Have you been fully vaccinated (had both vaccine shots)? Yes No

If yes, what was the date you received the second vaccine? _____

Do you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with have any of the following symptoms?

Fever (defined as above 100.4 degrees)? Yes No

Cough? Yes No

Fatigue? Yes No

Shortness of breath and/or trouble breathing? Yes No

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

New loss of taste or smell? Yes No

Muscle or body aches? Yes No

Have you or your child traveled out of Connecticut in the past 14 days? Yes No
(With the exception of NY, RI, or NJ)

If yes, did you quarantine for 5 days and then have a PCR Test done on day 6? Yes No
(Please note that if answered no you will need to reschedule your appointment)

Was the PCR Test results positive? Yes No

Are you in the midst of awaiting test results for COVID? Yes No
(If yes, your appointment needs to be rescheduled)

Have you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with, tested positive for or been diagnosed as having COVID-19 or any other communicable disease? Yes No

If yes provide approximate date of illness _____ through _____
Symptom start date Symptom end date

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

Patient Name

Patient/ Guardian Name (if applicable)

Patient/Parent/Guardian Signature

Relation

Date