BRANDI HOWARD-STICKEL
& ASSOCIATES, DDS, LLC

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COVID-19 CONSENT

This patient disclosure form seeks information from you that we must consider before making treatment decisions during the circumstances of the COVID-19 virus.

Do you have a fever or above normal temperature?	☐ Yes	☐ No
Have you experienced shortness of breath or had trouble breathing?	☐ Yes	☐ No
Do you have a dry cough?	☐ Yes	☐ No
Have you recently lost or had a reduction in your sense of smell?	☐ Yes	☐ No
Have you recently lost or had a reduction in your ability to taste?	☐ Yes	☐ No
Do you have a sore throat?	☐ Yes	☐ No
Have you had contact with any KNOWN positive COVID-19 patient?	☐ Yes	☐ No
Have you tested positive for COVID-19?	☐ Yes	☐ No
Have you been tested for COVID-19 and are awaiting results?	☐ Yes	☐ No
Have you traveled within the United States by air or cruise in the past 14 days?	☐ Yes	☐ No
Have you traveled within the United States by air, bus or train within the past 14 days?	☐ Yes	☐ No

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Patient or Responsible Party Date