AAOIC SUPPLEMENTAL WELLNESS QUESTIONNAIRE

Patient Name: _____ Date: _____

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, 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? Date_____

Have you, your child, or others accompanying you to today's appointment or other recent acquaintances traveled in the past 14 days to any region affected by COVID-19? (as relevant to your location)

Yes_____ No_____

If yes, when? Date_____

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

•A Fever (defined as above 99.6 degrees) Yes_____ No_____

•A Cough? Yes_____ No_____

•Shortness of Breath and/or Trouble Breathing? Yes_____ No_____

•Persistent Pain, Pressure, or Tightness in the Chest? Yes_____ No_____

•Chills, Repeated Shaking with Chills? Yes_____ No_____

•Muscle pain? Yes_____ No_____

•Headache, sore throat? Yes_____ No_____

•New loss of taste or smell? Yes_____ No_____

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

_____ _____

Patient/Parent's Signature Date