Dentistangpinoy.com

CLINIC NAME : _____
Screening Form Phase 2 Triage

Name: _____Age: ____Sex:_____Contact No: _____
Address: _____
Occupation: _____Body Temp: _____

QUESTION	YES	NO
1. In the past 14 days, have you or any member of your household, traveled to any areas with known cases of COVID-19		
If so, please state the exact location		
2. In the past 14 days, have you or any member or your household has had any contact with any COVID-19 patient?		
3. Have you or any household member have any history of exposure to any COVID-19 biological material (e.g. saliva)		
4. Have you had any history of fever for the last 14 days?		
5. Have you had any symptoms in the last 14 days such as: cough, nausea, diarrhea, loss of taste, difficulty breathing, body ache, loss of smell, fever?		
6. Urgent dental need in the last 14 days such as un controlled dental/oral pain, swelling, bleeding, infection, trauma?		
INFORMED CONSENT	**Conforme (Please Sign initial)**	
1. I give my full consent to have dental treatment done to me in this time of pandemic caused by COVID-19 disease.		
2. As explained by my dentist, the virus can be transmitted by contact through surfaces and that it can stay in the air for 5 to 72 hours. I am aware that it is impossible to identify who is probable, suspect or COVID-19 positive. Because of this, treatment options are limited to urgent and emergent care to protect me, other patients and the dental staff.		
3. I recognize that the clinic is adhering to the strictest infection control protocols for my protection and such, I agree cover the fees that this entails.		
4. I fully understand The risk that because of the nature of the virus, travelling to the clinic, the clinical procedures, and even by simply staying in the dental office, I have a higher chance of contracting the virus. Should I contract the virus, I hereby agree that I shall not hold the dental office liable.		
5. I am also giving my consent that in accordance to the IATF rules, my identity shall be revealed for possible contact tracing for the interest and safety of the community.		
I am TRUTHFULLY answering the questionnaire and fully understood the informed consent form. CONFORME: (sign here)		
Patient's or Guardian's Full Name : Relation to Patient:		
Date signed:		