George J. Papasikos, D.M.D., P.A.

2022 COVID SCREENING AND CONSENT

Please Read and Sign Below before your appointment.

Full Name_____

Address_____

Phone Number _____

Email_____

Are you experiencing any of the following?

Do you have a persistent cough? ___YES ___NO

Do you have a fever (above 98.6) ___YES ___NO

Have you lost or experiencing a reduced sense of taste or smell? ___YES ___NO

Have you been in contact with anyone with COVID 19 symptoms or living in a household with someone who is self isolating due to covid-19 symptoms? ___YES ___NO

If YES to any of the above, please follow the CDC guidelines. All dental appointments must be rescheduled.

Signed

I declare that the information I have provided is true to the best of my knowledge.

Signature:_____

Date_____

PRINT