Belle Hall Dentistry
Family and Cosmetic

Dear Patient,

We hope this letter finds you and your family in good health. Our community has been through a lot over the last few months, and all of us are looking forward to resuming our normal habits and routines. While many things have changed, one thing has remained the same: our commitment to your safety.

Infection control has always been a top priority for our practice and you may have observed this during your visits to our office. Our infection control processes are made so that when you receive care, it is both safe and comfortable for all parties involved. We want to tell you about the infection control procedures that we follow in our practice to keep all patients and staff safe.

Our office follows infection control recommendations made by the American Dental Association (ADA) and the United States Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA). We monitor the decisions and follow the protocols of these agencies so that we are up to date on any new rulings or guidance that may be issued. We do this to make sure that our infection control procedures are current and adhere to each agencies' recommendations.

You will be seeing some changes at the office when it is time for your next appointment. We made these changes to help protect our patients and staff.

- Our office will communicate with you beforehand, either by phone or email to ask you various screening questions. You will be asked those same questions again upon entry to the office.
- We have hand sanitizer that we will ask you to use when you enter the office.
- You may notice that our waiting room will no longer offer magazines, children's toys and so forth, since those items are difficult to clean and disinfect.
- Appointments will be managed to allow for social distancing between patients. That might mean that you are offered fewer options for scheduling your appointment.
- We will do our best to allow greater time between patients, but we may ask you to remain waiting in your vehicle until we call you in to reduce the number of patients in the waiting area.

We look forward to seeing you again and are happy to answer and questions you may have about the steps that we take to keep you, and every patient, safe in our practice.

Thank you for being our patient. We value your trust and loyalty and look forward to welcoming back our patients, neighbors, and friends.

Sincerely,

Dr Oldham, Dr Guerrino, Anna, Cheryl, Emily, Darlene, and Erika

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

A weak or compromised immune system **(including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition),** can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

PATIENT NAME	PRE-APPOINTMENT	IN- OFFICE
	DATE:	DATE:
Do you have a fever or above normal temperature?	☐YES ☐NO	☐YES ☐NO
Have you experienced shortness of breath or had trouble breathing?	☐YES ☐NO	☐YES ☐NO
Do you have a dry cough?	☐YES ☐NO	☐YES ☐NO
Have you experienced any flu-like symptoms like GI upset, headache, or fatigue?	☐YES ☐NO	☐YES ☐NO
Have you recently lost or had a reduction in your sense of taste or smell?	☐YES ☐NO	☐YES ☐NO
Is your/their age over 60?	☐YES ☐NO	☐YES ☐NO
Do your/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	☐YES ☐NO	☐YES ☐NO
Have you been in contact with someone who has tested positive for COVID-19?	☐YES ☐NO	☐YES ☐NO
Have you been tested for COVID-19 and are awaiting results?	☐YES ☐NO	☐YES ☐NO
Have you tested positive for COVID-19?	☐YES ☐NO	☐YES ☐NO
If you tested positive for COVID-19, have you received 2 negative tests since your last day of symptoms? If NO follow up test received: ● Has it been 14 days since symptoms 1st appeared? **Y** or **N** ● Are you 72 hours fever free without fever reducing medication? **Y** or **N**	DATE OF 1ST NEGATIVE TEST _____ DATE OF 2ND NEGATIVE TEST _____ ☐NA	☐NA
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐YES ☐NO	☐YES ☐NO
Have you traveled within the United States by air, bus or train within the past 14 days?	☐YES ☐NO	☐YES ☐NO

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

X _____ X_____ _____

Signature of Patient (Parent or Guardian if Minor) | Witness | Date

PATIENT DISCLOSURES: COVID-19 QUESTIONNAIRE COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I hereby knowingly and freely acknowledge, and assume any and all risks, known and unknown, related to the potential contraction of COVID-19 during the dental procedure and/or treatment, and assume full responsibility for such risk. I hereby agree to indemnify and hold harmless the Provider, its employees, officers, owners, doctors, directors, members, managers, members, contractors, agents and/or representative from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, which may be brought as a result of the dental procedures and/or treatment provided on the date identified below or hereafter as such treatment and/or procedure may be related to the contraction of COVID-19. _____ (Initial)

The undersigned, on behalf of myself as well as any of my heirs, personal representative or assign, hereby release, waive, discharge, and covenant not to sue the Provider, or any of the Provider's employees, officers, owners, doctors, directors, members, managers, contractors, agents, and/or representatives for any and all claims, known or unknown, which may be related to the transmission and/or contraction of COVID-19, including but not limited to claims which may result in personal injury, illnesses (including death), loss of income or other property loss.

_____ (Initial)

I have read and understand the information stated above:

X _____ X_____ _____

Signature of patient (Parent or Guardian if Minor) | Witness | Date