ORTHODONTIC ASSOCIATES OF MERCER ISLAND
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SUPPLEMENTAL HEALTH QUESTIONNAIRE

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 disease transmission and to keep you and our community safe and healthy. We appreciate your cooperation with this process.

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: _________

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

1. A fever (defined as a temperature above 99.6 degrees) Yes: ______ No: ______
2. A Cough? Yes: ______ No: ______
3. Shortness of breath and/or trouble breathing? Yes: ______ No: ______
4. Persistent pain, pressure or tightness in the chest? Yes: ______ No: ______
5. Any other flu like symptoms such as GI upset or headache? Yes: ______ No: ______
6. Have you experienced recent loss or taste or smell? Yes: ______ No: ______
7. Are you over the age of 60? Yes: ______ No: ______
8. Do you have heart, lung or kidney disease? Yes: ______ No: ______
9. Do you have diabetes or an auto-immune disease? Yes: ______ No: ______
10. Have you traveled in the past 14 days to any place or region affected by COVID-19 relevant to your geographic location? Yes: ______ No: ______

I understand that if the answer to any of these questions is "YES", I will be asked for further information and I may be asked to re-schedule my appointment based on my answers to these questions to protect the health of our community at large.

Patient Name: ______________________________ Date: ____________________

Parent/Responsible Party/Authorized Legal representative

(Signature)______________________________ (Printed Name) ______________________________

Relationship to the patient: ______________________________

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