Wellness Screening and Treatment Consent
Cornejo Orthodontics

Welcome! We are so happy to see you! Please help us ensure the safety of everyone in the office by completing this form.

Patient Name: ______________________________________ Date: ____________________

In the last 14 days including today, has the patient, a family member, or anyone the patient may have come in contact with had/have any of the following?

Fever or above normal temperature (over 99 degrees F)....................................Yes No

Coughing…………………………………………………………………………...Yes No

Shortness of Breath or Difficulty Breathing…………………………………………..Yes No

Persistent pain, pressure or tightness in chest……………………………………...Yes No

Travel by airplane, bus, train or cruise ship…………………………………………..Yes No

Runny nose or sore throat……………………………………………………….…..Yes No

Lost or had a reduction in sense of smell………………………...………………….. Yes No

Diagnosis of COVID-19 infection, or any other communicable disease……………...Yes No

Date of Diagnosis: ________________

Waiting for results of test for COVID-19 infection………………………………………. Yes No

If the answer is yes to any of the previous questions, I understand I will be asked to reschedule today's appointment.

Please be assured that our office has always met or exceeded the requirements set forth for sterilization and infection control from the CDC and OSHA, and will continue to do so. However, it is possible to contract COVID-19 infection (or any other communicable disease) in any public space. Our office has added a number of new barriers, techniques, and protocols to enhance the level of safety for all in the office. Even with these additional measures in place, there is still a risk of contracting the COVID-19 virus or any communicable disease.

By signing this document, I fully understand and accept the risks involved, and I consent to orthodontic treatment in the office of Stephanie A. Cornejo, DDS, PA. I acknowledge that the answers I have provided above are true and accurate.

X ____ Date: ___________________________

Signature of patient (Parent or Guardian if minor)

____ ________________________________

Printed name of parent/guardian Relationship to patient