Spring Valley
Dental Group

Out of concern for our patients, dentists and team members, our office is following the recommendation of the Centers for Disease Control and avoiding close contact with patients who are sick.

Please indicate below if you currently have, or had had any of these symptoms in the last 4 weeks:

- **Fever:** _____YES _____NO _____
  Patient temperature at time of appt.
- **Flu-like symptoms:** _____YES _____NO
- **Cough:** _____YES _____NO
- **Shortness of Breath:** _____YES _____NO

In addition:

Have you been in direct contact with anyone who has COVID-19?

_____YES _____NO

Have you traveled outside the United States in the last 4 weeks?

_____YES _____NO

If you answered yes to either of these questions, we respectfully ask that you reschedule your dental appointment.

Sincerely,

Your Dental Professionals at Spring Valley Dental Group

Patient mobile phone number to send via text a 48 hours follow-up COVID-19 screening questionaire:

_____

Patient Signature:_____ **Date:**_____