COVID QUESTIONNAIRE

Patient Name_____

1. Do you have any cold or flu symptoms or have you tested positive for Covid 19?

   Yes_____ No_____

2. Have you been around anyone with Covid 19 within the last 2 weeks?

   Yes_____ No_____

3. Although exposure is unlikely, do you accept the risk and consent to treatment?

   Yes_____ No_____

Patient/Parent's Signature_____ Date_____