Connecticut Maxillofacial Surgeons, LLC

Addendum to Health History Questionnaire

Patient Name: _____ Date: _____

Temperature Upon Arrival _<100.4 – Afebrile: _____

1. Have you tested positive or have had close contact with someone who has tested positive for COVID-19? No ☐ Yes ☐
2. Are you feeling well today? Yes ☐ No ☐

   If No, please explain: _____
3. Have you had any flu or cold virus symptoms: cough, shortness of breath, fever, shivering/shaking chills, joint pain, headaches, sore throat, or loss of taste or smell in the past 3-5 weeks? No ☐ Yes ☐

   If Yes, please explain: _____
4. Have you traveled outside of the United States in the past 14 days? No ☐ Yes ☐

   If Yes, please explain: _____
5. Have you traveled domestically with the United States by commercial airline, bus, or train within the past 14 days? No ☐ Yes ☐

   If Yes, where: _____

I knowingly and willing consent to have dental treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious _____ (initial)

Preferred Pharmacy: _____

Address: _____

All of us at CTMAX are committed to taking the best possible care of our patients and protecting the safety of both our staff and patients. Thank you for taking the time to complete this questionnaire.