Mrunal Parmar, DDS
www.thesmilestop.com
info@thesmilestop.com
Tel: (201) 391-8516

Dear Parents/Guardian:

I acknowledge and understand there is an increased risk COVID-19 can be transmitted in any place of public accommodation, including a dental office and I have been informed that my dentist desires to protect the safety of the dental office, patients and staff and other individuals who come upon the premises.

A weakened or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID‐19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to us any indication of having been exposed to COVID‐19, or whether you or your child have experienced any signs or symptoms associated with the COVID‐19 virus.

	Yes	**No**
Do you or your child have a fever or above normal temperature?	☐	☐
Have you or your child experienced shortness of breath or had trouble breathing?	☐	☐
Do you or your child have a dry cough?	☐	☐
Do you or your child have a runny nose?	☐	☐
Have you or your child recently lost or had a reduction in your sense of smell?	☐	☐
Do you or your child have a sore throat?	☐	☐
Has anyone in your immediate family been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you or your child tested positive for COVID-19?	☐	☐
Have you or your child been tested for COVID-19 and are awaiting results?	☐	☐
Has anyone in your immediate family traveled outside of the US in the past 14 days? If so, where?	☐	☐

Temperature: (Office use only – day of visit) Child: _____ Parent/Guardian: _____

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system. **By signing this document, I acknowledge that the answers I have provided above are true and accurate and provide consent to the performance of treatment proposed by my dentist.**

Name of Parent / Guardian: _____

Signature of Parent / Guardian: _____

Relationship to Child: _____ Date: _____