Patient Advisory and Acknowledgment
Receiving Dental Treatment During the COVID-19 Pandemic

Marshall Orthodontics, Dental Practice of Yo Imai-Marshall, D.D.S.

Dear Patient:

Please acknowledge the following:

- While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- In order to reduce the risk of spreading COVID-19, we will be asking everyone to fill out a patient screening form once in the parking lot. Please be aware that depending on your answer, you may need to be rescheduled. We advise that you look at the patient screening form questions at this time to become familiar with the questions.
- In addition, we will be taking temperatures at the office. If your temperature is greater than 100.4°F, we are unable to see you and you will be rescheduled. For improved accuracy of temperature measurements, please do not eat or drink anything hot or cold within 30 minutes of your appointment.
- We will also be measuring your oxygen levels with a fingertip oximeter. If you have unhealthy oxygen levels we are unable to see you and you will be rescheduled. We will also recommend you see a physician immediately.
- Masks or facial coverings will be required to enter the office.
- Before certain procedure types, you may be asked to use a mouthwash at the office.

Please answer the following. If your answer is yes to any of them, please contact our office to discuss how to proceed:

Yes	No	
◯	◯	You are over 65 years of age.
◯	◯	You have heart disease, lung disease, kidney disease, diabetes, or blood disease.
◯	◯	You have liver disease, severe obesity (BMI ≥40), or any auto-immune disorders.
◯	◯	You have a compromised immune system.
◯	◯	You are or may be pregnant.

If you have any questions or concerns, please contact our office.

I have answered the above questions honestly and to the best of my knowledge.

_____
Patient Name

_____
Signature of Patient/Responsible Party

☐ By checking this box and typing my name above, I am electronically signing this form.

_____
Date

_____ _____
Responsible Party Name (if other than patient) Relationship to Patient (if other than self)