Dear Caregiver,

Welcome to Jersey City Pediatric Dentistry. This form is required when presenting a child or children to our office for dental treatment. While our office complies with the New Jersey 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.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, please answer the following screening questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers. If we are unable to reach you for your pre-screening form, your appointment may be canceled and rescheduled.

Safety of our patients, family and team is our top priority. During this pandemic, we are required to have significant amounts of additional PPE for dental procedures. There will be a "COVID19 PPE safety Fee" of $10/per patient visit and $20/family max/visit. We will submit this to your insurance and make all efforts to get this covered however we cannot make any guarantees.

If you need to cancel your appointment, we do require at least a 24 hour cancellation notice to avoid a $50 cancellation fee. We require a confirmation at least 48 hours in advance. Fee will be waived if you/child are ill. If no notice is provided and you do not show to your appointment you will be subject to a $50 fee.

Check both:

☐ I understand there will be a $10 per patient/$20 max per family "COVID-19 PPE Safety Fee" applied to each dental appointment

☐ I have read and understand the "No Show and Cancellation Policy"

Parent/Guardian Signature: _____

Parent/Guardian Print Name: _____ Date: _____

Child's Name: _____

Prescreening questionnaire:

Regarding the patient (child):	No	Yes
Are you currently awaiting the results of a COVID-19 test?		
Are you in contact with any confirmed COVID-19 positive patients?		
Do you have a fever?		
Do you have any shortness of breath?		
Do you have a dry cough?		
Do you have a runny nose?		
Do you have a sore throat?		
Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?		
Have you experienced headaches, fatigue or weakness?		
Have you lost your sense of taste and/or smell?		
Within the last 14 days, have you travelled to any regions affected by COVID-19?		
If yes, where? _____		