**CHESTERFIELD ORTHDONTICS**

**COVID-19 SUPPLEMENTAL HEALTH QUESTIONNAIRE**

Have you, your child, or others accompanying you to today’s appointment or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease?

Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

If yes, when? Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you, your child, or others accompanying you to today’s appointment or other recent acquaintances have:

\*A Fever (defined as above 99.6 degrees) Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

\*A Cough? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

\*Shortness of Breath and/or Trouble Breathing? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

\*Persistent Pain, Pressure, or Tightness in the Chest? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

I understand that if the answer to any of these questions is yes, I will be asked to reschedule today’s orthodontic appointment