



**CENTRAL JERSEY PROSTHODONTICS, P.C.**  
**ANDREW PRAMER, D.D.S.**  
NJ SPECIALTY PERMIT #3651

**Patient Request for Treatment,  
Representations and Consent**

Responding to the public health hazard posed by Coronavirus disease 2019 ("COVID-19"), effective 5:00 p.m. on Friday, March 27, 2020, Governor Philip D. Murphy ordered and directed the suspension of all surgeries or invasive procedures performed on adults that can be delayed without undue risk to the current or future health of the patient as determined by the patient's treating physician or dentist.

I acknowledge and understand that there is an increased risk that 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 and the patients, staff and other individuals who come upon the premises

Accordingly, as a precondition to rendering treatment, I have confirmed that I have no symptoms commonly associated with COVID-19, including fever, shortness of breath, dry cough, running nose or sore throat and that I have not, within the past 14 days, travelled by airplane, been in close proximity (less than 6 feet proximity) at a gathering of 10 or more persons, or had close contact with a person who has confirmed positive or suspected to be positive for COVID-19.

I consent to the performance of the treatment proposed by my dentist.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Patient Screening Form

**Patient Name:**

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.