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COVID-19 QUESTIONNAIRE & CONSENT

With community transmission of communicable diseases, you could be exposed anywhere to infectious diseases including, but not limited to COVID-19 (also called Coronavirus). Our office is following the recommended CDC regulations and personal protection and disinfection protocols to limit transmission of communicable diseases. Social distancing has reduced the transmission of COVID-19; however, it is not possible to provide ophthalmic treatment with social distancing between the patient, ophthalmologist, optometrist, staff and sometimes, other patients.

It is possible that these precautions will not always be successful in blocking the transmission of these diseases. By presenting yourself or your family for ophthalmic treatment, you assume and accept the risk that you or your family may inadvertently be exposed to a communicable disease.

If you have been exposed to a communicable disease prior to your ophthalmic appointment, you may spread the disease to the ophthalmologist, optometrist, staff and to other patients in the practice. Therefore, prior to each appointment, we require you to answer the following questions:

1. **Have you, your family, or others accompanying you to today's appointment been tested positive for or been diagnosed as having COVID-19? ☐ Yes ☐ No If so, when? Date ________________________________**
2. Have you traveled outside the U.S. or outside the Tri-State Area in the past 14 days (2 weeks)? ☐ Yes ☐ No If yes, where: ________________________________
3. Has a close contact (household member) traveled outside the U.S. in the past 14 days (2 weeks)? ☐ Yes ☐ No If yes, where: ________________________________

4. Have you been in contact with a person who has flu-like symptoms such as cough, fever and body-ache or any other known infectious disease? ☐ Yes ☐ No

5. Do you have a fever (Temperature more than 100.4 ° F (38 °C))? ☐ Yes ☐ No

6. Do you have a cough, shortness of breath, tightness in chest or sore throat? ☐ Yes ☐ No

7. Have you been vomiting or do you have diarrhea? ☐ Yes ☐ No

If any of you have any of these symptoms or have recently tested positive for or been diagnosed with COVID-19, you will be asked to reschedule your appointment.

Do you acknowledge and accept the risk of exposure in our office to a communicable disease, included but not limited to COVID-19, and consent to treatment? ☐ Yes ☐ No

Patient Name: ____

Patient Signature: ____

Date: ________________________

If Patient is a minor, please have a legal guardian sign below.

Guardian Name: ____

Guardian Signature: ____

Date: ________________________