Bobby T. Shirley, DMD • Clay Cannon, DMD

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Do you have, or have you recently had any flu like symptoms, including but not limited to; chills, cough, shortness of breath, body aches, diarrhea, nausea, vomiting, or loss of taste or smell?	YES / NO
Do you suspect you have a fever or have you been exposed to anyone who has?	YES / NO
Have you traveled outside of The United States in the past month?	YES / NO
Have you previously been asked to isolate or self-quarantine?	YES / NO
Have you had close contact to an individual diagnosed with the COVID-19 infection?	YES / NO
Have you been tested for COVID-19? If yes, please explain and include results	YES / NO

CONSENT FORM FOR DENTAL SERVICE

I, _________________________ hereby on this date of ___/___/2020 am choosing to be seen at Distinctive Dentistry for my dental need on my accord. I understand that there are risks associated with today's visit. I fully accept and release the doctor and the staff at Distinctive Dentistry from any responsibility related to any likelihood of contracting COVID-19 during today's dental visit. I have answered all of the above questions truthfully.

Patient Name:____ Witness: ______________________________________

Patient Signature:____