



BACK TO PRACTICE
PATIENT CARE

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Covid-19 Patient Screening Form

Instructions for use: Use one form for each patient appointment. Ask the patient these questions at the time appointment is made or with appointment reminder, and again no more than two days before the appointment. Take the patient's temperature and note any signs of fever, coughing, or shortness of breath.

Patient/Parent/Guardian Names: _____

Screening questions	Date: / / Staff initial: _____	Date: / / Staff initial: _____	Notes
Do you have a fever or above-normal temperature (>100.4° F)? <i>Take temperature at appointment.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>If patient answers "yes" to either question on shortness of breath or coughing, or answers yes to any combination of two other symptoms and the patient does not need emergency care, consider not scheduling or seeing the patient until symptoms resolve or until patient can provide proof they are not infectious for COVID-19. The dentist may want to seek additional information from the patient regarding symptoms.</i>
Are you experiencing shortness of breath or having trouble breathing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a dry cough?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a runny nose?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a sore throat?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Are you experiencing chills or repeated shaking with chills?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have unexplained muscle pain?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a headache?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Screening questions	Date: / / Staff initial: _____	Date: / / Staff initial: _____	Notes
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>If yes, ask for date of last contact with COVID-positive patient and set appointment time for more than 14 days later, unless the patient needs emergency care.</i>
Have you been tested for COVID-19 in the last 14 days? <i>If "no," proceed to next question.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<p><i>If yes, what is the result of the testing?</i></p> <p><i>If negative, proceed to next question.</i></p> <p><i>If still waiting on results, schedule appointment after results are known.</i></p>	<input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Positive	<input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Positive	<i>If positive, determine if patient needs emergency care. If not an emergency, schedule patient to be seen when it has been more than 7 days since symptoms first appeared and 3 days of no fever without use of fever-reducing medication.</i>
Have you traveled more than 100 miles from your home in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<i>If yes, determine if patient traveled to an area where COVID-19 cases are high. Determine if patient followed physical distancing precautions and wore a mask while in public. Use professional judgement when determining whether to proceed with the appointment.</i>

Patient signature required at appointment:

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature _____

Patient-Dentist Arbitration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would be determined by submission to arbitration as provided by California Law, and not by a lawsuit, or resort to court process, except as California law provides for judicial review or arbitration proceedings. Both parties of this contract by entering into it, have given up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:

The term "patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:

Patient understands and agrees that any dispute of the sort described in Article I between doctor and patient will be subject to compulsory, binding arbitration.

C. Coverage of Pre-Natal Claims (If Applicable):

Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort described in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes:

In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running or statute of limitations for ninety (90) days.

B. Method of Initiating Arbitration:

If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.

C. Applicable Law:

The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.

The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator's decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.

The prevailing party shall be entitled to attorney fees.

Article IV.

A. Revocation:

If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL, SEE ARTICLE I OF THIS CONTRACT.

PATIENT'S NAME: (Please Print): _____ DATE: _____

SIGNED: _____ Patient/Legal Guardian

SIGNED: _____ Witness

DOCTOR SIGNATURE _____