Warren B. Branch, D.D.S.
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COVID - 19 SELF-DECLARATION FORM

Due to the ongoing & rapidly changing situation with the COVID-19 Virus, we are requesting that all patients please complete this form before your dental appointment.

1) Have you been diagnosied or Tested for COVID-19? **YES or No**

If Yes:
Date You were Tested:
Were you tested again?

2) Do you have ANY of these Flu like symptoms?

Fever	YES	NO
Cough	YES	NO
Shortness of Breath	YES	NO
Dry Cough	YES	NO
Runny Nose	YES	NO
Sore Throat	YES	NO

3) Have you traveled outside of Texas area within the last 2 weeks?

YES **NO**

If **Yes**, Name of Place & returned date:

4) Have you or an immediate family member come in close contact with a confirmed case of the COVID-19 in the last 14 days? **YES** or **NO**

I confirm That I have NOT been in close contact with a confirmed case of COVID-19 with 14 days:	Initial

The health & wellbeing of our community is our first priority and therefore, our office reserves the right to deny entry to our office.

Patient/Guardian Signature

Date

Staff Member

Temperature Reading: