Elevated Dental | 2109 N Frontage Rd W, Ste B | Vail, CO | 970-476-3991

Patient Self-Declaration

In the past 14 days have you:

Tested positive for, been diagnosed, or presumably diagnosed, with COVID-19?
Yes □ No □

Experienced a loss of taste or smell, or flu-like symptoms such as cough, fever, shortness of breath, body aches or diarrhea?
Yes □ No □

Have you been in close contact with another person who has been diagnosed or is presumed to have COVID -19, or showing any of the symptoms listed above?
Yes □ No □

My signature indicates:

1. I have read the above questions and answered them truthfully. I understand that by answering yes, I may be asked to reschedule my appointment to maintain the health and safety of the staff and patients of Elevated Dental.
2. Elevated Dental is taking all recommended precautions to ensure the risk of patients and staff spreading COVID-19 is minimized. I do understand, however, that there is still a risk of being exposed to COVID-19 and other diseases in any healthcare facility.

Patient or Guardian Signature: _____

Date: _____