Southern Dental Group

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Have you recently tested positive for COVID-19?	Yes/No
Have you recently been exposed to someone who tested positive for COVID-19?	Yes/No
Have you recently been exposed to someone who is suspected to have COVID-19?	Yes/No
Have you recently traveled to countries under a travel ban?	Yes/No
Do you currently have a temperature of 100 degrees or higher?	Yes/No
Are you currently having any symptoms of Acute Respiratory Infection? For example: coughing or shortness of breath	Yes/No
I certify that I have given correct and accurate information pertaining to my healtl pandemic.	n and the COVID-19
Patient Name (Printed):	-
Relationship to Patient:	
Parent/Guardian Name (Printed):	
Signature (Patient or Parent/Guardian):	
Date:	