FAMILY VISION ASSOCIATES

YOUR VISION IS OUR FOCUS™

COVID Questionnaire

Name: ____

Date of Birth: ____

Email Address: ____

Please circle Yes or No for each of the following questions

Have you tested positive for or have a COVID test pending?	Yes	No
Have you experienced any symptoms of a COVID infection such as cough, shortness of breath, fever, or loss of smell in the past two weeks?	Yes	No
Have you been in close contact with anyone who has tested positive for COVID or has shown symptoms in the last two weeks?	Yes	No
Have you traveled by plane or to any hotspots in the past two weeks?	Yes	No

PATIENT CONSENT and WAIVER for VISIT AND PROCEDURES

Family Vision Associates, its doctors, and staff are taking precautions to reduce any potential exposure to the COVID-19 virus.

I believe my office visit(s) and procedures performed here are essential to maintain my eye health.

I understand that there is no way to eliminate all potential exposure to COVID-19 when I visit and travel to and from this office, but I am willing to assume the risk.

I understand that COVID-19 infection can lead to illness, or disability, and knowingly assume the risk of exposure as I deem my exam to be essential to the maintenance of my health.

I will not hold Family Vision Associates, its doctors or staff legally responsible should I become positively or presumptively diagnosed with the COVID-19 virus.

Signature: ____ Date: ___________________