

Mount Vernon Dental Group

mountvernondentalgroup.net

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(770)396-8061

Have you had cough, fever, shortness of breath or any Covid-19 related symptoms in the past 10 days? * Yes No

Have you been in contact with anyone showing Covid-19 symptoms within the past 10 days? * Yes No

Have you or anyone you've been in contact with tested positive for Covid-19 in the past 10 days? * Yes No

Temperature (will take in office) : _____

Signature _____ Date _____

Response Date: _____