VISIONARY
EYE CARE PROFESSIONALS

Please read the following statements and initial next to each to indicate your agreement.
If you cannot positively affirm any of the questions*, please contact the office.*

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, body aches, rash on the skin, fingers or toes, loss of smell, loss of taste or other cold / flu symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has, a confirmed diagnosis or a presumptive positive test result for Covid-19, in the last 30 days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of the state in the last 30 days.

Current protocols in office:
Whenever possible, the patient should come to their appointment alone.
Anyone entering the office must be wearing a face mask that covers their nose and mouth.
Anyone entering the office will have their temperatures taken with a non-contact thermometer.
Anyone with a temperature above 100.4º will be asked to reschedule.
Anyone entering the office will be asked to wash their hands upon arrival.

In an effort to reduce the need to touch surfaces in the office, we require patients to fill out all required medical history documents a minimum of two hours prior to their appointment time.

If you or anyone in your household starts to experience Covid-19 symptoms between the time you fill out this form and the time of your appointment, please call the office to reschedule your appointment.

There are certain inherent risks associated with an eye exam during this pandemic and I assume full responsibility for any personal illness that may result. I understand that Visionary Eye Care Professionals, its doctors and its staff, are taking precautions to limit any potential exposure to the Covid-19 virus. I also understand that there is no definitive way to completely eliminate any potential exposure. By signing, I deem my eye care visit to be essential to my eye health and vision.

Patient name (print): _____

Relationship to patient: _____

Signature: _____ Date: _____