EYESHAPES HOBOKEN COVID-19 SUPPLEMENT

Todays Date: _____/_____/_____

Name: _____ Date of Birth:_____/_____/_____

Do you currently have ANY of the following symptoms?

Fever [ ], Chills (shaking w/chills) [ ], Cough [ ], Rash on feet or torso [ ], Muscle pain/ache [ ], Headache [ ], Sore Throat [ ], Loss of taste or smell [ ], Shortness of breath/difficulty breathing [ ]

Have you had any of the above symptoms in the last 14 days? Yes [ ], No [ ]

If YES, please specify: _____

When did symptoms begin? _____/_____/_____. When did symptoms end? _____/_____/_____

Have you been tested for COVID-19? Yes [ ], No [ ]

If YES, when? _____/_____/_____ Were results?: Positive [ ], Negative [ ]

Have you had contact with any person who has tested positive for Covid-19, or has shown symptoms associated with Covid-19? Yes [ ], No [ ]

If YES, when _____/_____/_____. Did you quarantine for 14 days following contact? Yes [ ], No [ ]

FOR YOUR SAFETY AND OURS

We will be requiring extreme **social distancing** and **face masks** for all. Surfaces and equipment will be **sanitized after each patient** visit. All **eyeglasses will be thoroughly cleaned** after any patient contact and all new **eyeglasses will be sent to you** to minimize unnecessary interaction. **Contact lens supplies will continue to be shipped** as well. There will be **no "walk-in"** browsing allowed.

1)No one may enter office without first calling the front desk at 201-653-2020

2)Only scheduled patients may enter. No visitors or guests. If patient is a child, they may be accompanied by one parent or guardian.

3)Patients may only enter if wearing face mask. We will screen for fever and symptoms, and ask patients to wash hands or use hand sanitizer before and after examination, and before and after choosing eyeglasses.

4)Please bring a pen to sign checks or charge slips, etc. We will not be able to supply pens at this time.