MOY FINCHER CHIPPS

Beverly Hills
Torrance
Encino

Facial Plastics & Dermatology

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American College of Mohs Surgery
American Society for Dermatologic Surgery
American Academy of Dermatology
American Academy of Facial Plastic Surgery
American Academy of Cosmetic Surgery

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Full Name: **Date of Birth:** **Date:**

Have you received your first and second dose of COVID-19 vaccine?	Yes No

Positive responses to any of the questions below would likely indicate a deeper discussion with the practice before proceeding with your appointment. Please make sure to contact the office.

Do you have fever, or have you felt hot or feverish recently? (14-21 days)	Yes No
Are you having shortness of breath or other difficulties breathing? Not due to any chronic conditions.	Yes No
Do you have a cough?	Yes No
Any other flu-like symptoms, such as sore throat, headache or fatigue?	Yes No
Have you experienced recent loss of taste or smell?	Yes No
Are you in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	Yes No
Have you traveled in the past 14 days to any regions affected by COVID-19? (As relevant to your location)	Yes No

This is an acknowledgement that I have agreed to have my medical care provided at the Moy-Fincher-Chipps (MFC) Medical office.

I understand that it is required to wear a face mask that fully covers the nose and mouth at the time of my appointment.

I understand that MFC will be following and observing all healthcare guidelines and precautions during our clinical and office hours.

I acknowledge that MFC can provide all the necessary health safety materials during my medical visit.

I understand that all the standard HIPAA, OSHA and CLIA procedures are being followed.

I understand if I exhibit any signs of illness, I will be asked to leave the office immediately for the safety of our staff and patients.

Signature: _____