

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition) can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus. Treatment can and will be denied to any patient who responds "yes" to any of the statements below.

	Yes	No
Do you have a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in close proximity (less than 6 feet proximity) at a gathering of 10 or more people for the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled by air, cruise ship, bus, or train in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had the COVID-19 vaccination? If yes, please write the date of vaccine: _____	<input type="checkbox"/>	<input type="checkbox"/>

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history that may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate. Therefore, I consent to the performance of the treatment proposed by my dentist.

Patient Name

Patient Signature

Date

Signature of parent or guardian if minor

Patient Temperature: _____