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.

Patient Name:

	Pre-Appointment	In-Office
Do you/they have a fever or above normal temperature(14-21days)?	YES NO	YES NO
Have you/they experienced shortness of breath or had trouble breathing?	YES NO	YES NO
Do you/they have a dry cough?	YES NO	YES NO
Do you or they have a runny nose?	YES NO	YES NO
Have you/they recently lost or had a reduction in your sense of smell?	YES NO	YES NO
Do you/they have a sore throat?	YES NO	YES NO
Do you/they have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES NO	YES NO
Have you/they been in contact with someone who has tested positive for COVID-19? (Patients who are well but who have a sick family member at home with Covid-19 should consider postponing elective treatment)	YES NO	YES NO
Is your/their age over 60?	YES NO	YES NO
Have you/they tested positive for COVID-19?	YES NO	YES NO
Have you/they been tested for COVID-19 and are awaiting results?	YES NO	YES NO
Have you /they traveled in the past 14 days to any regions affected by COVID-19? (As relevant to your/their location)	YES NO	YES NO
Have you/they traveled outside the United States by air or cruise ship in the past 14 days?	YES NO	YES NO
Have you/they traveled within the United States by air, bus or train within the past 14 days	YES NO	YES NO

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 which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ Signature_____ Date

_____ Witness