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 reschedule 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 sign or symptom associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or reduced in sense of smell and/or taste?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside of the US by air or cruise ship in the past 14 days?		
Have you traveled within the US by air, bus, or train within the last 14 days?		

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 results 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