COVID-19 PATIENT DISCLOSURE

Patient Name: _____ TEMP_____ °F

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

A weakened 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 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.

	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 lost your sense of smell or taste?		
Do you have a sore throat?		
Have you had contact with a Covid-19 positive person?		
Have you tested positive for Covid-19?		
Have you been tested for COVID-19 and are waiting results?		
Have you traveled outside of the US in the past 14 days? If so where? _____		

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 and agree to the guidelines that the answers I have provided above are true and accurate.

Parent/Guardian's Signature: _____ Date:_____

DR. Signature _____ Date: _____

COVID-19 PATIENT DISCLOSURE

Parent/Guardian's *Name:* _____*TEMP*_____*°F*

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

A weakened 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 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.

	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 lost your sense of smell or taste?		
Do you have a sore throat?		
Have you had contact with a Covid-19 positive person?		
Have you tested positive for Covid-19? DATE:		
Have you been tested for COVID-19 and are waiting results?		
Have you traveled outside of the US in the past 14 days? If so where? _____		

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 and agree to the guidelines that the answers I have provided above are true and accurate.

Parent/Guardian's Signature: _____ Date:_____

DR. Signature _____ Date: _____