COVID-19 PATIENT SCREENING AND DISCLOSURE FORM

This patient disclosure form seeks information from you that we must consider before making treatment decision 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, 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.

	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 or sore throat?		
Have you recently lost or had a reduction in your sense of smell or taste?		
Do you have chills or unexplained muscle pain?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you been tested for COVID-19? Result:		
Have you traveled outside the US in the past 14 days?		

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to this dental office any condition 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.

______________________________ ______________________________ ______________________

Name – Printed *Name – Signature* Date

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Dental Office Witness