

COVID-19 Pandemic – Patient Disclosures

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

A weak or compromised immune system (Including, but not limited to: Asthma, diabetes, 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 that you or your child have been exposed to COVID-19, or whether you or they have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or temperature 100.4°F or above?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Have you recently lost or had a reduction in your sense of smell or taste?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside the United States by air or by cruise ship in the past 14 days?		
Have you traveled within the United States by air, bus, or train within the past 14 days?		

Have you had a flu shot in the past 2 weeks? _____ Yes _____ No

If yes, did you experience a fever or any adverse reaction? _____ Yes _____ No

If yes, please explain _____

Signature

Date

Witness

Date