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(Printed): _____ **DOB:** _____

Appointment Date and Time: _____ **Temp at check-in**: _____

	PHONE SCREEN		**IN-OFFICE**	
	YES	**NO**	**YES**	**NO**
Do you have a fever or have you felt hot or feverish in the past 14-21 days?				
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 had reduction in your sense of smell?				
Do you have a sore throat?				
Any other flu-like symptoms, such as upset stomach, headache, or fatigue?				
Have you been in contact with someone who has tested positive for COVID-19?				
Have you tested positive for COVID-19/ or have you been tested for COVID-19 and are awaiting results?				
Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?				
Have you traveled in the past 14 days out of the country/or with in the United states in areas affected by COVID-19?				

I fully understand and acknowledge the about 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 SIGNATURE