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.

1) Do you currently have a fever of 100.4 degrees Fahrenheit or higher, a cough, runny nose, shortness of breath or difficulty breath or difficulty breathing?
   Yes No
2) Have you or a family member traveled **OUTSIDE** of the USA within the past 14 days?
   Yes No
3) Have you or a family member traveled **WITHIN** the USA within the past 14 days?
   Yes No
4) Have you been on a cruise ship **WITHIN** the past 14 days?
   Yes No
5) Have you attended any events or gatherings with more than 100 people?
   Yes No
6) Have you been in close contact with anyone who has a **confirmed** COVID-19 diagnosis?
   Yes No
7) Have you tested positive for COVID-19 or awaiting results?
   Yes No
8) Have you or a family been asked to self-quarantine?
   Yes No

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

Patient or Guardian Signature: _____ Date: _____