COVID-19 Pandemic Patient Disclosures Form

Patient's name: _____
(Printed name of patient)

The intent of this form is to establish the state of your health which must be considered before making treatment decisions in the midst of the COVID-19 virus pandemic.

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 indicate below any condition that compromises your immune system with the understanding that we may ask you to consider rescheduling treatment after discussing any such conditions with you.

It is also critical that you disclose any indication or suspicion of having been exposed to COVID-19 as well as any signs that you may have experienced symptoms associated with the COVID-19 virus.

	YES	NO
Are you experiencing a fever (temperature above 100.4°F / 38°C)?	☐	☐
Have you recently experienced shortness of breath or trouble breathing?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of taste or smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been experiencing chills?	☐	☐
Have you been experiencing muscle pain?	☐	☐
Have you been in contact with anyone 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 U.S. in the past 14 days?	☐	☐
Have you traveled within the U.S. via public transport within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to Prestige Dental any conditions in my health history which may result in a compromised immune system. By signing this document I acknowledge that the answers I provided above are true and accurate.

_____
Signature of patient, parent, guardian or agent of power of attorney

_____
Date

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