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COVID-19 HEALTH SCREENING FORM - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstances 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.

Have **you or any of your household members** experienced the following symptoms?

	Yes	No
Nausea, vomiting or diarrhea?		
Fever or above normal temperature?		
Shortness of breath or had trouble breathing?		
Dry cough?		
Congestion or a runny nose?		
Lost or had a reduction in your sense of smell?		
Sore throat?		

In addition, have **you or any members of your immediate household**...

	Yes	No
Been in contact with someone who has tested positive for COVID-19?		
Tested positive for COVID-19?		
Been tested for COVID-19 and are awaiting results?		
Traveled outside the United States by air or cruise ship in the past 14 days?		
Traveled within the United States by air, bus or train 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 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.

_____ _____ _____

Print Patient Name | Patient Signature (parent if minor) | Date

_____ _____

Dr. Signature | Date