COVID-19 PANDEMIC – PATIENT DISCLOUSRES

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.

	YES	NO
Do you or any family members have a fever or above normal temperature?	◯	◯
Are you or any family members experiencing shortness of breath or having trouble breathing?	◯	◯
Do you or any family members have dry cough?	◯	◯
Do you or any family members have a runny nose?	◯	◯
Have you or any family members have recently lost or have had a reduction in your sense of smell?	◯	◯
Do you or any family members have a sore throat?	◯	◯
Even if you or any family members don't currently have any of the above symptoms, have you or any family member experienced any of these in the last 14 days?	◯	◯
Have you or any family members been in contact with someone who has tested positive for COVID-19 in the last 14 days?	◯	◯
Have you or any family members tested positive for COVID-19?	◯	◯
Have you or any family members been tested for COVID-19 and are awaiting results?	◯	◯
Have you or any family members traveled outside the United States by air or cruise ship in the past 14 days?	◯	◯
Have you or any family members traveled within the United States by air, bus, or train within the past 14 days?	◯	◯
Is anyone in the household under the 14 day quarantine?	◯	◯

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider and 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: _____

COVID-19 Pandemic Emergency Dental Treatment Consent Form

I, _____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is not possible to determine who has the virus and who doesn't given the current limits in COVID-19 testing.

Dental procedures create aerosol spray which is how the disease is spread. The ultra-fine nature of the aerosol spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, _____ (Initial)

- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus and I am unable to be seen for my dental appointment until after the 14 day quarantine. _____ (Initial)

- I understand if I have been exposed to the COVID-19 virus I am unable to be seen for my dental appointment until after 14 day quarantine. _____ (Initial)

Signature: _____Date: _____

Submit