

DENTAL HEALTH CARE CENTER

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This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19, also known as "Coronavirus," 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 disclose to us any condition that compromises your immune system and understand that such disclosures may impact treatment decisions.

People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness.

These symptoms may appear 2-14 days after exposure to the virus. It is important that you disclose 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 been in contact with someone who has tested positive for COVID-19? * Yes No

Have you tested positive for COVID-19? * Yes No

Have you been tested for COVID-19 and are awaiting results? * Yes No

Have you traveled outside the United States or to high-risk areas in the past 14 days? * Yes No

Do you have a fever or above normal temperature? * Yes No

Have you taken any fever-reducing medications, including: ibuprofen (Advil, Motrin or other), acetaminophen (Tylenol or other), naproxen (Aleve or other) or aspirin in the last 14 days and, if yes, for what reason? *

Yes No

Have you experienced shortness of breath or had trouble breathing? * Yes No

Do you have a cough? * Yes No

Do you have a runny nose? * Yes No

Have you recently lost or had a reduction in your sense of smell? * Yes No

Do you have a sore throat? * Yes No

Have you experienced chills or repeated shaking with chills? * Yes No

Do you have muscle pain? * Yes No

Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? * Yes No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? * Yes No

Do you otherwise feel unwell? * Yes No

I fully understand and acknowledge the above information, risks and cautions and have disclosed to my provider any other conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

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Signature _____ Date _____

Response Date: ___/___/___