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

If yes: What was the date of your test? _____

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

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Do you otherwise feel unwell? * ◯ Yes ◯ No

Do you agree to contact our office if you develop any of these symptoms or test positive with COVID-19 within 2 days of your appointment today? *

◯ Yes ◯ No

NOTES ON ANY OF THE ABOVE:

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: ____/____/_____