

COVID-19 PATIENT DISCLOSURE

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstances of regarding -COVID-19.

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. For your safety and ours please disclose below any condition that potentially compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with you.

	Pre-Appointment		In-Office	
	Yes	No	Yes	No
Have you/family been in contact with someone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your family tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your family been tested for COVID-19 and are awaiting results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family traveled outside the United States by air or cruise ship in the past 21 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or anyone in your family have a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your family experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or anyone in your family have a cough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or anyone in your family have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you or anyone in your family recently lost or had a reduction in your sense of smell?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or anyone in your family have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you/your family experienced chills or repeated shaking with chills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient or you otherwise feel unwell?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

Patient or Legal Representative Signature

Date

Print Patient or Legal Representative Name/Relationship

Witness Signature (optional)

Date