Pre-Appointment Questions- Patient Disclosures

Covid-19 Pandemic is a serious medical crisis and we are taking the safety and health of our patients and of our team members very seriously. As we move to reopening and and prioritizing our schedule by urgency of need, we are implementing several additional safety measures.

This patient disclosure form seeks information from you that will help in considering dental treatment at this time. Your dental health remains a critical part of your overall but decreasing the viral transmission in our community is essential. A weak or compromised immune system can put you at greater risk for contracting COVID-19 and we may want to consider rescheduling your dental treatment after reviewing these screening questions.

PATIENT NAME:	YES	NO
1) Do you or have you had any flu-like symptoms in the last 14 days? • Cough		
• Shortness of breath		
• Or at least two of the following symptoms?		
○ Fever		
○ Chills		
○ Sore throat		
○ New loss of taste or smell		
○ Extreme muscle aches		
○ Nausea		
○ Vomiting		
○ Diarrhea		
2) Are you awaiting results from a lab test for COVID-19?		
3) Have you tested positive for COVID-19?		
4) Have you had an antibody test for COVID-19?		
5) Have you or a family member been asked to self-quarantine in the past 14 days?		
6) Have you had close contact with an individual diagnosed with COVID-19 infection in the past 14 days?		
7) Have you traveled in the past 14 days to a region with high rates of COVID-19 disease activity?		

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

______________________________ ______________________

Signature Date

____

Patient name