Updated 2/24/2021

COVID-19 HEALTH SCREENING FORM - PATIENT DISCLOSURES

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
1. Have you been fully vaccinated for COVID-19? *(If someone is fully vaccinated, they have received both doses of a COVID-19 vaccine, and it has been 14 days since their second dose.)* If **YES,** skip to question 12. You do not need to answer questions 2-11.		
2. Do you have a fever or above normal temperature?		
3. Have you experienced shortness of breath or had trouble breathing?		
4. Do you have a dry cough?		
5. Do you have a runny nose?		
6. Have you recently lost or had a reduction in your sense of smell?		
7. Do you have a sore throat?		
8. Have you been in contact with someone who has tested positive for COVID-19? If yes, what was the date? ________________________		
9. Have you tested positive for COVID-19? If yes, what date did you test positive? ____________________________		
10. Have you been tested for COVID-19 and are awaiting results?		
11. If you have COVID-19, how long have you been free of symptoms?	Provide Date:	
12. Have you traveled outside the United States by air or cruise ship in the past 14 days?		

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.

_______________________ _______________________ _______________________

Print Patient Name | Patient Signature (parent if minor) | Date

____

Witness