COVID-19 Screening

This patient disclosure form seeks information from you that we must consider before making treatment decisions during the COVID-19 pandemic.

A weakened or compromised immune system (which may be due to underlying conditions like cancer, diabetes, asthma, and COPD; treatments like radiation, chemotherapy, and immunosuppressive drugs; 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 or treatment/medication that weakens or 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 COVID-19.

Please check:	Yes	No
Do you/they feel feverish or have you had a fever or a temp 100.4° F or above in the last 14-21 days?		
Have you/they experienced shortness of breath or had trouble breathing?		
Do you/they have a dry cough?		
Have you/they had any other flu-like symptoms such as chills or repeated shaking with chills, headache, Gastrointestinal upset?		
Have you/they recently lost your sense of smell or taste?		
Do you/they have a sore throat?		
Have you/they been in contact with someone who has tested positive for COVID-19? (In the past 14days)		
Have you/they tested positive for COVID-19? (In the past 14 days)		
Have you/they been tested for COVID-19 and are awaiting results?		

I fully understand and acknowledge the above information, risks and cautions regarding a weakened or compromised immune system and have disclosed to my provider any conditions in my health history which may result in a weakened or compromised immune system.

COVID-19 Pandemic Supplemental Informed Consent and Acknowledgement of Risk Form