Your Letterhead

Covid-19 Patient Disclosures

Please read and answer all of the questions below. When done, sign it and mail it to this office. Thank you for your support in this matter.

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.

Patient's: First Name _____ Last Name_____ Date of Birth _____

Please answer *ALL* of the questions below to the best of your knowledge if you have been experiencing any of the symptoms below either *now* or within the past 14 days?	Pre-Office Appointment Response	To be filled in at your Appointment
Do you have a fever or felt hot/feverish in the last 14 days?	O Yes O No	O Yes O No
Are you experiencing shortness of breath or other breathing difficulties?	O Yes O No	O Yes O No
Do you have a dry cough?	O Yes O No	O Yes O No
Do you have a runny nose?	O Yes O No	O Yes O No
Have you recently noticed a reduction of your sense of taste or smell?	O Yes O No	O Yes O No
Do you have a sore throat?	O Yes O No	O Yes O No
Are you feeling nauseous lately?	O Yes O No	O Yes O No
Have you been experiencing diarrhea?	O Yes O No	O Yes O No
Are you feeling fatigued?	O Yes O No	O Yes O No
Are you having muscle aches more than the usual?	O Yes O No	O Yes O No
Have you been experiencing headaches?	O Yes O No	O Yes O No
Have you been tested for Covid-19 recently?	O Yes O No	O Yes O No
Have you tested positive?	O Yes O No	O Yes O No
Are you awaiting the results of your test?	O Yes O No	O Yes O No
Have you traveled out of your local area in the last 14 days?	O Yes O No	O Yes O No
Have you traveled out of the Unites States in the last 14 days?	O Yes O No	O Yes O No
Do you feel that you might have a compromised immune system?	O Yes O No	O Yes O No
Have you been in contact with someone testing positive to Covid-19 in the last 14 days?	O Yes O No	O Yes O No
Have you been in contact with the family members of someone testing positive for or who has been diagnosed for Covid-19 in the last 14 days?	O Yes O No	O Yes O No
Thank you for completing this questionnaire, please sign below and mail (email) your form to our office.		

Signature of patient or responsible person_____ Date:_____