

Your Letterhead

Covid-19 Patient Disclosures

Please read and answer all of the questions below for this on-line form. When done, sign it and click on the SEND button 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 Full Name

Patient's Date of Birth (xx/xx/xxxx)

First Name

Last Name

Birth Date

Please answer ALL of the questions below to the best of your knowledge if you have been experiencing any of the symptoms below either <i>now</i> 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?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Are you experiencing shortness of breath or other breathing difficulties?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Do you have a dry cough?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Do you have a runny nose?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Have you recently noticed a reduction of your sense of taste or smell?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Do you have a sore throat?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Are you feeling nauseous lately?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Have you been experiencing diarrhea?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Are you feeling fatigued?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Are you having muscle aches more than the usual?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Have you been experiencing headaches?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Have you been tested for Covid-19 recently?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Have you tested positive?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Are you awaiting the results of your test?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Have you traveled out of your local area in the last 14 days?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Have you traveled out of the Unites States in the last 14 days?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Do you feel that you might have a compromised immune system?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Have you been in contact with someone testing positive to Covid-19 in the last 14 days?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Thank you for completing this questionnaire, please sign below and click on the SEND button below.		

Signature of person filling this out:

Date: