COVID-19 PRE SCREENING

The patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus. Please disclose to us any condition that compromises your immune system and understand that we may consider rescheduling treatment after discussing any such conditions. 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 INFORMATION

FIRST NAME .....

LAST NAME .....

DOB .....

PHONE NUMBER .....

DATE OF APPOINTMENT .....

QUESTIONNAIRE

Do you have fever or above normal temperature?

Yes No

Have you experienced shortness or breath or had trouble breathing?

Yes No

Do you have a dry cough?

Yes No

Do you have a runny nose?

Yes No

Have you been in contact with someone who has tested positive for COVID-19?

Yes No

Have you tested positive for COVID-19?

Yes No

Have you traveled outside of the US in the past 14 days?

Yes No

If so, where?

Yes No

I fully understand and acknowledge the above information, risks, and cautions regarding a comprised 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.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)