

## COVID-19 Questionnaire

**Patient Disclosure:**

This patient disclosure form obtains 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 condition 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
Do you have a fever or above normal temperature?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested positive for COVID-19?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19 and are awaiting results?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled outside the United States by air or cruise ship in the past 14 days?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled within the United States by air, bus or train within the past 14 days?.....	<input type="checkbox"/>	<input type="checkbox"/>

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.

\_\_\_\_\_  
Signature of patient (parent or guardian if minor)

\_\_\_\_\_  
Date

### COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic. COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental Procedures can create a fine water spray known as an aerosol which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

**Patient Acknowledgement**

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

\_\_\_\_\_  
Signature of patient (parent or guardian if minor)

\_\_\_\_\_  
Date