COVID-19 PATIENT DISCLOSURE

*This patient disclosure form seeks information from you that we must consider as reccomended by both the American Dental Association (ADA) and Center for Disease Control (CDC). The answers you provide will be used prior to making treatment decisions for your dental care in light of the COVID-19 virus pandemic.

*It is important for you to know that a compromised immune system (including but not limited to: conditions such as diabetes, asthma, COPD, cancer treatments, radiation, chemotherapy, & any prior or current disease or medical condition) can put you at a 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 postpone and/or reschedule your planned treatment until further medical clearance is provided for the benefit of your well being.

*It is important that you disclose to our 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, including but not limited to:

DATE of Appointment:								
Temperature upon arrival:								
Have you had a fever above 100.4 F in the last 14 days?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Have you experienced recent shortness of breath or had trouble breathing?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Do you have a dry cough?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Do you have a runny nose?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Have you recently lost or had a reduction or your sense of taste or smell?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Do you have a sore throat?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Have you been in contact with someone who has tested positive for COVID-19?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Have you been tested for COVID-19?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
(If so please note +/- and date of result)	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -
Have you been tested for COVID-19 and are awaiting results?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Have you been tested for COVID-19 Antibodies?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
(If so please note +/- and date of result)	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -
Have you traveled outside of New Jersey in the last 14 days?	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
(If so please list location of travel)								
Please initial for each appointment date:	x	x	x	x	x	x	x	x

*I fully understand & 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.

NAME: _____

Signed: _____

DATE: _____

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