COVID-19 PANDEMIC—PATIENT DISCLOSURES ADULT Temp:_____F

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of 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 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 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.

	PATIENT
● Do you have a fever or above normal temperature?	YES or NO
● Have you experienced shortness of breath or had trouble breathing?	YES or NO
● Have you recently lost or had a reduction in your sense of smell?	YES or NO
● Do you have a runny nose?	YES or NO
● Do you have a dry cough?	YES or NO
● Do you have a sore throat?	YES or NO
● Have you had contact with someone who tested positive for COVID-19?	YES or NO
● Have you tested positive for COVID-19?	YES or NO
● Have you been tested for COVID-19 and are awaiting results?	YES or NO
● Have you traveled outside the United States by air or cruise ship in the past 14 days?	YES or NO
● Have you traveled within the United States by air, bus, or train within the past 14 days?	YES or NO

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 or true and accurate.

Patient Name:_____DOB:_____

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____

COVID-19 PANDEMIC DENTAL TREATMENT
NOTICE AND ACKNOWLEDGEMENT OF RISK FORM (ADULT)

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long intubation period. You or your healthcare provider may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to the limited availability for virus testing.

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 the dental office.

Dental procedures create a water spray which is one way the disease is spread. The ultra-fine nature the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I also acknowledge that I could contract COVID-19 virus from outside this office and unrelated to our visit here.

I have read and understand the information stated above:

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____