Pediatric Dental Healthcare
Specialists in Pediatric Dentistry and Orthodontics

Patient Name _____ **Patient Temperature** _____

Patient Date of Birth _____ **Parent/Guardian Temperature** _____

COVID-19 Pandemic - Patient Disclosures

This patient disclosure form requests information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

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
Have you had a fever within the last 24 hours?		
Have you experienced trouble breathing, muscle aches or excessive fatigue?		
Do you have a cough, runny nose or sore throat? If so, please explain.		
Have you recently lost or had a reduction in your sense of smell or taste?		
Have you or any household members been tested for COVID-19 and are currently awaiting results?		
Have you or any members of your household tested positive for COVID-19? If so, when?		
Have you traveled out of state within the past 10 days?		

I confirm that I have read and understand the Notice of Risk for COVID-19 and accept the additional risk of contracting COVID-19 at this office. I also acknowledge that I could contract the COVID-19 Virus from outside this office unrelated to my visit here.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Patient Signature (parent or guardian if patient under 18 years of age) _____ **Date** _____

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