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 seek 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 condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions 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
Have you had a fever within the last 14 days?		
Have you experienced shortness of breath of had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or had a reduction in your sense of smell or taste?		
Do you have a sore throat?		
Have you been tested for COVID-19 and are awaiting results?		
Have you tested positive for COVID-19?		
Have you traveled within the past 14 days?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and had 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 (or Parent/Guardian) Signature _____ **Date** _____
(parent or guardian if patient under 18 years of age)

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