COVID-19 PANDEMIC - PATIENT SCREENING DISCLOSURES

Colorado regulations permit resuming dental & surgical procedures before vaccine or virus cure is available.

This patient disclosure form seeks information that we must consider as we make diagnostic and treatment decisions during the COVID-19 virus outbreak. Our priority is safely providing our patients with their needed treatments.

A weak or compromised immune system (including, but not limited to, conditions such as diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), may put individuals at greater risk for contracting COVID-19. Please disclose to us any condition that compromises the patient's immune system. Please understand that we may ask patients to reschedule treatment after discussing any such conditions with us.

It important that you disclose to this office any indication of having been exposed to COVID-19, or whether you (or the child patient) have experienced any signs or symptoms associated with the COVID-19 virus.

Patient (or Guardian of child patient) Please answer the following questions:	**Yes**	**No**
Do you (or the child patient) have a fever or above normal temperature?		
Have you (or the child patient) experienced shortness of breath or had trouble breathing?		
Do you (or the child patient) have a dry cough?		
Do you (or the child patient) have a runny nose?		
Have you (or the child patient) recently lost or had a reduction in your sense taste or smell?		
Do you (or the child patient) have a sore throat?		
Have you (or the child patient) been in contact with someone who has tested positive for COVID-19?		
Have you (or the child patient) tested positive for COVID-19?		
Have you (or the child patient) been tested for COVID-19 and are awaiting results?		
Have you (or the child patient) traveled outside the United States by air or cruise ship in the past 14 days?		
Have you (or the child patient) traveled within the United States by air, bus or train within the past 14 days?		

I 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.

Patient's name (please print) _____ Signature of patient, legal guardian or authorized representative _____ Date _____

Witness _____ Date _____