COVID 19 PANDEMIC – PATIENT DISCLOSURES

This patient disclosure form seeks 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 prior or current disease or medical condition), can put you at 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 conditions with us.

It is 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
Do you have a fever or above normal temperature / felt feverish recently (within last 14-21 days)?		
Have you experienced shortness of breath or had trouble breathing?		
Please circle any you have or recently had - Dry cough / Runny nose / Sore throat		
Have you recently had a loss or change in you sense of smell?		
Have you recently had a loss or change in your sense of taste?		
Do you now or recently had flu like symptoms- headache, fatigue, gastrointestinal upset?		
Circle any of these you may have: Heart disease; Kidney disease; any Auto-immune disorders		
Been in contact with someone who has tested positive for COVID 19 within the last 14-21 days?		
Have you tested positive for COVID 19? Date_____		
Have you been tested for COVID 19 and are waiting results? Date _____		
Have you traveled outside the United States within the past 14-21 days?		
If applies to current restrictions: Have you traveled out of New York State in the last 14 to 21 days?		
Where did you travel to? Return date?		
Optional: Dates of Covid vaccine Date 1st_____ Date 2nd_____		

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 which may result in a compromised immune system.

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

_____

Print Name

_____

Signature

_____

Date