COVID-19 Pandemic – Patient Disclosures

This patient disclosure form seeks information from your family/household 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 child's (or your) immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

Please answer each line for your family/household:	YES	NO
Does anyone in the household have a fever, a dry cough, a sore throat, experienced shortness of breath, lost their sense of taste or smell?		
Does anyone in the household have asthma or respiratory concerns, Type 1 or 2 diabetes, autoimmune disease, is immunocompromised, is being treated for cancer, or undergoing treatment for kidney disease?		
Has anyone in the household been tested for COVID-19 and are awaiting results? When did you last experience symptoms?		

PATIENT NAME_____

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 are true and accurate.

Signature of Patient/Guardian: _____ Date: _____