



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.

It is also important that you disclose to our office any indication of having been exposed to COVID-19 or any other virus, or whether you have experienced any signs or symptoms associated with the COVID-19 virus or any other virus.

Please answer each line for your family/household:	YES	NO
Does anyone in the household have a fever or above normal temperature?		
Has anyone in the household experienced shortness of breath or had trouble breathing?		
Does anyone in the household have a dry cough?		
Does anyone in the household have a runny nose?		
Has anyone in the household recently lost or had a reduction in their sense of smell?		
Does anyone in the household have a sore throat?		
Does anyone in the household have Type 1 or Type 2 Diabetes?		
Is there anyone in your household under treatment for any autoimmune diseases?		
Has anyone in the household been diagnosed with being immunocompromised (low functioning immunity)?		
If so, what is the condition and how is it currently being managed?		
Does anyone in your household have Asthma or other Respiratory concerns? (if so, what kind? Exercise induced or Seasonal)		
Is anyone in the household currently being treated or followed for cancer?		
Is anyone in the household currently undergoing treatment for kidney disease with dialysis?		
Has anyone in the household been in contact with someone who has tested positive for COVID-19 in the last 2 weeks?		
Has anyone in the household tested positive for COVID-19? If so, when? When did you last experience symptoms?		
Has anyone in the household been tested for COVID-19 and are awaiting results? When did you last experience symptoms?		
Has anyone in the household traveled outside the United States by air or cruise ship in the last few weeks?		
Has anyone in the household traveled within the United States by air, bus, or train within the last few weeks?		

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: _____

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COVID-19 Pandemic Dental Treatment Notice and Acknowledgement of Risk Form

Parent/Guardian Temperature: _____ Parent/Guardian Temperature: _____ Initial: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Patient Name: _____ Birthdate: _____ Temperature: _____

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of the dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

The patient cannot wear a protective mask over their mouth to prevent infection during treatment as the health care providers need access to their mouth to render care. This leaves the patient vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with the dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at our office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

Signature of Patient/Guardian: _____ Date: _____

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