COVID-19 PATIENT DISCLOSURE

This patient disclosure form seeks information that must be taken into consideration prior to determining treatment needs amidst the COVID-19 pandemic.

Individuals with weak or compromised immune systems are at greatest risk for contracting COVID-19. This includes patients with conditions such as, but not limited to, diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current medical condition. We ask that you disclose any condition that may compromise your immune system. Please be advised that treatment may be rescheduled in the interest of the health and safety of our patients and team.

If you have been exposed to COVID-19 or are experiencing any signs or symptoms associated with the virus, it is essential that you share this information with a team member prior to receiving treatment.

	YES	NO
Do you have a fever or above normal (97°F-99°F) temperature?		
Have you experienced trouble breathing or shortness of breath?		
Do you have a dry cough?		
Do you have a sore throat?		
Are you experiencing any cold or flu like symptoms (body aches, chills, etc.)?		
Have you or someone you're in close contact with traveled outside the United States in the past 14 days?		
Have you or someone you're in close contact with traveled within the United States by air, bus, or train within the past 14 days?		
Have you been exposed to someone who tested positive for COVID-19 or exhibited symptoms in the 14 days before you got sick?		
Have you been tested for COVID-19?		

If yes, were the results?	Positive	Negative	Awaiting Results

By signing this document, I acknowledge that I fully understand the above information and have disclosed to my provider any medical conditions, symptoms, or recent travel that may be attributed to a compromised immune system or increased level of exposure.

_____ _____

Signature Date

_____

Witness