This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstances 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 also 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
Have you or anyone you reside with		
Traveled outside of the country within the last 30 days?		
Traveled domestically, in the country, within the last 30 days?		
If Yes, Please list: _____		
Are you or anyone you reside with currently experiencing any of the following?	Yes	No
Fever or above normal temperature		
Dry Cough		
Runny Nose		
Sore Throat		
Have you or anyone you reside with	Yes	No
Tested positive for COVID-19?		
Been tested for COVID-19 and are awaiting results?		
Been exposed to anyone who has tested positive for COVID-19?		

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.

_____ _____

Patient Name (Printed) Guardian Name (Printed, if different from patient)

_____ _____

Patient/Guardian Signature Date

Thank you for choosing Neighborhood Dental