Health Questionnaire and Treatment Consent

If you have been exposed to COVID-19, you may spread the disease to our doctor, our team, or other patients at our practice. This patient disclosure form seeks information from you that will inform us before making treatment decisions amid the COVID-19 virus.

Pre-Existing Conditions

A weakened or compromised immune system can put you at greater risk for contracting COVID-19. Please disclose to us any medical condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

Health Disclosure

	Yes	No
Have you, your child, or others accompanying you to today's appointment tested positive for or been diagnosed with COVID-19?		
Do you have a fever (above 99.6 degrees)?		
Do you have shortness of breath or trouble breathing?		
Do you have a dry cough, sore throat, or runny nose?		
Have you recently lost or had a reduction in your sense of smell?		
Have you been in contact with someone who has tested positive for COVID-19?		
Are you awaiting the results of a COVID-19 test?		

Informed Consent

While our office adheres to standard precautions and regulations regarding safety and sterilization, COVID-19 ("Coronavirus") is a communicable disease. Despite our careful attention to sterilization, disinfection, and use of personal protective equipment, there is still a chance that you could be exposed to COVID-19 in our office.

While we have taken measures to practice social distancing in our office, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, doctor, staff, and sometimes other patients at all times. Although exposure to COVID-19 at our office is unlikely, we require your consent before continuing with your treatment.

By signing this document, I acknowledge that the answers I have provided above are true and accurate to the best of my knowledge. I also accept the risk of treatment and provide my consent.

Patient/Parent Signature Date