BARON FAMILY DENTISTRY

COVID-19 PATIENT DISCLOSURES

This Patient Disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weakened or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy and any other prior or current disease or medical condition), can put you at a 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 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.

Please check the appropriate box...	YES	NO
Do you have a fever or above normal temperature?		
Have you had trouble breathing or experienced shortness of breath, flu-like symptoms, headache, fatigue, or upset stomach?		
Do you have a runny nose, sore throat, or dry cough?		
Have you recently lost or had a reduction in your sense of smell or taste?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19 or awaiting test results?		
Have you traveled outside of the US in the past 14 days? If so, where? _____		
Have you had a vaccine? Moderna ____ Pfizer ____ J & J ____ Vaccine Shot #1 Date: _____ Vaccine Shot #2 Date: _____		

I fully understand and acknowledge the above information is true and accurate. I also understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office. I understand that my dentist desires to protect the safety of the patients, staff, and other individuals who enter the premises.

_____ **EMAIL:** _____

Name (Please Print)

_____ **Date:** _____

Signature