Los Gatos Family Dentistry
COVID-19 PANDEMIC 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 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
Do you have a fever or above normal temperature (>100 F)?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or had a reduction in your sense of smell?		
Do you have a sore throat?		
Are you experiencing chills or repeated shaking with chills?		
Do you have unexplained muscle pain?		
Do you have a headache?		
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?		
Have you been in contact with someone is being tested or who has tested positive for COVID 19 in the last 14 days?		
Have you tested positive for COVID 19 in the last 14 days?		
Have you been tested for COVID 19 and are awaiting results?		
Have you traveled more than 100 miles from your home in the past 14 days?		
Have you traveled within the United States by air, bus or train within the past 14 days?		

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. I agree to notify the dental practice if within 2 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 2 days.

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Name

_________________________________ _________________________________
Signature Date