## COVID-19 PANDEMIC - Appointment Screening Form Online - Oct 2020-2

Welcome to our office! This patient disclosure form seeks information from you that we must consider before making treatment decisions due to the ongoing COVID-19 virus pandemic.

Please Note: 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.

Patient Name: _____

| *Please check the appropriate box next to each question.* | **Yes** | **No** |
|---|---|---|
| Have you been tested for COVID-19 and are awaiting results? | ☐ | ☐ |
| Have you tested positive for COVID-19? | ☐ | ☐ |
| As of today do you have a fever, chills, or above normal temperature? | ☐ | ☐ |
| Have you experienced shortness of breath or had trouble breathing? | ☐ | ☐ |
| Do you have a dry cough? | ☐ | ☐ |
| Do you have a runny nose? | ☐ | ☐ |
| Have you been in direct contact with someone who has tested positive for COVID-19? | ☐ | ☐ |
| Have you been quaratined for any reason within the past 14 days? | ☐ | ☐ |
| Have you recently lost or had a reduction in your sense of smell? | ☐ | ☐ |
| Have you traveled outside of Texas within the past 14 days? If yes, where?_____ | ☐ | ☐ |
| We now offer a 30 second mint flavored disinfecting rinse prior to each appointment. Do you wish to USE this rinse? | ☐ | ☐ |

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. I also understand that I will notify this office if I experience COVID-19 symptoms within 2 days of this appointment or receive a positive test result.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature (Parent/Guardian/Patient) Date and time of form completion

_____

Staff reviewer

Patient Temperature (to be taken by staff) _____ °F

Other person _____ °F Relation _____

Initial _____