COVID-19 PANDEMIC PATIENT DISCLOSURE

The patient disclosure form seeks information from you that we must consider before making treatment decision during **the COVID-19 outbreak.**

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 conditions), 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 PRIOR TO CONFIRMING YOUR DENTAL APPOINTMENT. CANCELLATION FEES APPLY, we have many patients that need to be seen.

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 COVID-19.

	YES	NO	YES	NO
Do you have fever or felt hot or feverish recently (last 14-21 days)?				
Are you having shortness of breath or other difficulties breathing?				
Do you have a cough?				
Any other FLU like symptoms, such as GI upset, headache or fatigue?				
Have you experienced any loss of taste or smell?				
Are you over 60?				
Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?				
Have you traveled in the past 14 days to any regions affected by COVID-19 (as relevant to your location?)				
	PRE-APPT		IN-OFFICE	

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.

_____ _____

Print Name and Signature Date

_____Witness

TEMPERATURE:

Dental Treatment Consent and Affirmation Form/ COVID-19 Reopening

1. I knowingly and willingly consent to dental treatment at Katrina Wall, DMD, LLC by Dr. Wall and any designated associates and employees during the reopening phase of COVID-19.
2. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has COVID-19 and who does not given the current limitations and availability in COVID-19 viral vesting.
3. Risk of transmission: I understand that due to the frequency of visits of other dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though standard precautions are being observed.
4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
    - Fever of 100.4 degrees Farenheit or 37 degress Celsius or higher
    - Shortness of breath
    - Dry Cough
    - Runny nose
    - Sore throat
    - Diminished sense of taste or smell
5. Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in paragraph 4 in the last 14 days.
6. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a known carrier of COVID-19 nor knowingly infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

_____ _____ _____

Patient's name | Signature of patient, legal guardian or authorized representative | Date

_____

Witness/Date