COVID-19 – Patient Disclosure & Symptom Check

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 such as radiation and chemotherapy, and any prior or current disease/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 your treatment after discussing such condition 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?	☐	☐
Have you experience shortness of breath or trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a sore throat?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in taste or smell?	☐	☐
Have you been contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside of the United States by air or cruise ship 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.

_____ _____

Print Name Signature

_____ _____

Date Witness

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT NOTICE AND

ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it *as a pandemic*. *You could contract COVID-19 from a variety of sources.* Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 while receiving dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability of virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in the dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine water spray can linger in the air for a long time, allowing transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Governor of Minnesota, the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment may now resume. According to the ADA, dental emergencies are “potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection.” The ADA also recommends that urgent dental care which “focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments” be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I also agree to follow the instruction and guidelines of the dental office, the Center for Disease Control and American Dental Association regarding proper precautions upon entering the office and understand that treatment may need to be rescheduled if those precautions are not followed. I understand additional risk of contracting COVID-19 from contact at this office. I acknowledge that I could contract the COVID-19 virus outside of this office in circumstances unrelated to my visit here.

I have read and understand the information stated above:

_____	_____	_____
Print Name	Signature	Date

_____

Witness