Daniel Barletta, D.M.D.
GENERAL 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 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 experience any signs or symptoms associated with COVID-19.

	YES	NO
• Do you have any fever 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 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?	_____	_____
• Have you been tested for COVID-19 and awaiting Results?	_____	_____
• Have you traveled outside the US in the past 14 days?	_____	_____

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 come upon the premises.

Name _____ Date_____