

**COVID-19 Pandemic Patient Disclosures**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19, also known as "Coronavirus," pandemic. 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 such disclosures may impact treatment decisions.

People with COVID-19 have had a wide range of symptoms reported. These symptoms may appear 2-14 days after exposure to the virus. It is important that you disclose any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	In-Office	
	Yes	No
Have you been in contact with someone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19 and are awaiting results?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a cough?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache, muscle pain, chills, or fatigue?	<input type="checkbox"/>	<input type="checkbox"/>

I fully understand and acknowledge the above information, risks and cautions and have disclosed to my provider any other conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient or Legal Representative Name/Relationship

\_\_\_\_\_  
Witness Signature (optional)

\_\_\_\_\_  
Date