COVID-19 PANDEMIC 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 pandemic.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer, radiation, chemotherapy, and any prior or current disease or medical condition) can put you at greater risk for contracting COVID-19. Please disclose 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.

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?	☐	☐
Do you have a dry cough?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Have you recently lost or had a reduction in your sense of smell or taste?	☐	☐
Have you traveled outside of Lincoln within the last 14 days?	☐	☐
Have you tested positive or been in contact with someone who has tested positive to COVID-19?	☐	☐
Are you or someone you have been in contact with awaiting results for a COVID-19 test?	☐	☐

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 the answers I have provided are true and accurate.

_____ _____

Signature & Printed Name Date

COVID-19 Pandemic 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 potentially increased risk of contracting COVID-19 associated with dental care.

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 a potential 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 nature of the water spray can linger in the air for a long time, allowing for 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 to access your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the notice above and understand and accept that there is a potentially increased risk of contraction the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature & Printed Name Date