

## 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 virus.

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 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?	<input type="checkbox"/>	<input type="checkbox"/>
Are you experiencing shortness of breath or having trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell/taste?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Are you feeling nauseous?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
Are you feeling fatigued?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have muscle aches?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been experiencing headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Even if you don't <i>currently</i> have any of the above symptoms, have you experienced <b>any</b> of these symptoms in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	<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"/>
Have you traveled outside of Rhode Island for any reason in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled outside of the United States for any reason in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness