**COVID-19 PANDEMIC – PATIENT DISCLOSURES**

**ORAL & MAXILLOFACIAL SURGERY, LTD.**

This patient disclosure form seeks information from you that we must consider before making treatment decisions for you in the circumstances 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 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 experienced shortness of breath or had trouble breathing? |  |  |
| Do you have a dry cough? |  |  |
| Do you have a runny nose or nasal congestion? |  |  |
| Have you recently lost or had a reduction in your sense of smell? |  |  |
| Do you have a sore throat? |  |  |
| Have you experienced malaise, chills or muscle aches? |  |  |
| Have you been in contact or exposed with/to someone who has tested positive of COVID-19? |  |  |
| Have you been tested for COVID-19 and are awaiting the results? |  |  |
| Have you tested positive of COVID-19? |  |  |
| 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? |  |  |
| Do you have any reason to believe that you have been directly exposed to COVID -19 virus through travel or contact with others? |  |  |

Record of basal metabolic temperature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Document patient disposition (cleared / not cleared): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_