Northtowns Oral & Maxillofacial Surgery, PLLC
COVID-19 PANDEMIC - PATIENT/ESCORT 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.

Do you have shortness of breath, difficulty breathing or a cough? Yes ☐ No ☐
Have you experienced recent loss of taste or smell? Yes ☐ No ☐
Have you tested positive for COVID-19? Yes ☐ No ☐ If yes, when?
Have you been in contact with any confirmed COVID-19 positive patients? Yes ☐ No ☐
Have you been tested for COVID-19 and are awaiting results? Yes ☐ No ☐
If yes, why were you tested?

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my employer 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

_____ _____

Print Name Temperature & Initials of Temperature Taker