PRE-APPOINTMENT WELLNESS SCREENING FORM

This patient disclosure form seeks information from you regarding your wellness that we must consider before making treatment decisions.

It is important that we understand whether you have 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) so we can properly address your dental needs in light of such medical conditions. Please disclose below and understand that we may ask you to discuss any such conditions with us.

Compromised Immune System Conditions

It is also important that you disclose to the 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. Please check or provide the requested information in the appropriate box for each question.

		YES	NO
1.	Do you have a fever or above-normal temperature (≥99° F)?		
2.	Are you experiencing shortness of breath or having trouble breathing?		
3.	Do you have a dry cough?		
4.	Do you have a runny nose?		
5.	Have you recently lost or had a reduction in your sense of smell or taste?		
6.	Do you have a sore throat?		
7.	Are you experiencing chills or repeated shaking with chills?		
8.	Do you have unexplained muscle pain?		
9.	Do you have a headache?		
10.	Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?		
11.	Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?		
12.	Have you been tested for COVID-19 in the last 14 days? *If "no," proceed to next question.*		
12a.	***If yes***, what is the result of the testing? ***If negative***, proceed to next question. ***If still waiting on results***, please indicate so that we can schedule appointment after results are known.		
13.	Have you traveled more than 100 miles from your home in the last 14 days?		
14.	Have you been social distancing and sheltering-in-place as per your county's order?		

Required Patient Signature

By signing this document, I acknowledge that the answers I have provided above are accurate and that I I agree to notify Shukhman Dental if within 14 days I become ill with any COVID-19 symptoms or test positive for COVID-19. I understand that Shukhman Dental has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature _____ Date: _____

Name _____