LA PERIODONTICS & IMPLANT SPECIALISTS

COVID−19 Patient Disclosure

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 fever, or have you felt hot or feverish recently (14-21 days)?	☐	☐
Are you having shortness of breath or other difficulties breathing?	☐	☐
Do you have a dry cough, sore throat, or a congested/runny nose?	☐	☐
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Have you tested positive for COVID−19?	☐	☐
Have you been in contact with someone who has tested positive for COVID−19? *Patients who are well but who have had a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐	☐
Is your age over 60?	☐	☐
Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	☐	☐
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐	☐
Temperature		

Positive responses to any of these would likely indicate a deeper discussion with Dr. Rana Shahi before proceeding with elective dental treatment.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Patient Name (Print) **Date**

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_____

Patient Signature

COVID-19 Acknowledgement of Risk Waiver

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 additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

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 an elevated risk of you contracting the virus simply by being in a 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 access to 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 an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept 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:

_____

Print Name of Patient Above

_____ _____

Patient / Parent or Guardian Signature **Date**