NDK DENTAL
(401) 884-3340

COVID-19 Pandemic – Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions 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 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 COVID-19 either before or 14 days after your appointment.

	YES	NO
Do you have a fever or above normal temperature?	☐	☐
Are you experiencing shortness of breath or having trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had reduction in your sense of taste/smell?	☐	☐
Do you have a sore throat?	☐	☐
Are you feeling nauseous?	☐	☐
Do you have diarrhea?	☐	☐
Are you feeling fatigued?	☐	☐
Do you have muscle aches?	☐	☐
Have you been experiencing headaches?	☐	☐
Even if you don't *currently* have any of the above symptoms, have you experienced **any** of these symptoms in the last 14 days?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside of Rhode Island for any reason within the past 14 days?	☐	☐
Have you traveled outside the United States for any reason in the past 14 days?	☐	☐

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_____