Bellevue Pediatric Dentistry, P.C.

Angeli J. Thakker, D.D.S

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Bellevue, NE 68123
(402) 291-5400

Name of Patient: _____ DOB: _____

COVID-19 - PATIENT 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 weakened 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 and/or your child** have experienced any signs or symptoms associated with the COVID-19 virus listed below:

	Yes	No
Fever or above normal temperature	☐	☐
Shortness of breath or trouble breathing	☐	☐
Dry cough	☐	☐
Runny nose	☐	☐
Recently lost or had a reduction in your sense of smell	☐	☐
Sore throat	☐	☐
Chills	☐	☐
Repeated shaking with chills	☐	☐
Muscle pain	☐	☐
Headache	☐	☐
Been in contact with someone who has tested positive for COVID-19	☐	☐
Tested positive for COVID-19	☐	☐
Tested for COVID- 19 and are awaiting results	☐	☐
Traveled outside Nebraska in the past 14 days If so, where? _____	☐	☐

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 of parent/legal guardian Date