

**Joseph V. Baldassano, D.D.S., M.S.D., LLC.**

**COVID-19 Pandemic Patient Disclosures and Dental Treatment Consent Form**

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus. While our office complies with the Illinois State Health Department and the Center for Disease Control and Prevention’s infection control guidelines to prevent the spread of COVID-19 virus, we cannot make any guarantees.

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.

For the safety of our staff, other patients and yourself, please 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 a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19 and are awaiting results?	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled within or outside the United States by air, bus, train or cruise ship in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you received the Covid-19 Vaccine yet?	<input type="checkbox"/>	<input type="checkbox"/>

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. I understand that the COVID-19 virus has an incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. Our office staff is symptom-free and to the best of their knowledge, they have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected with or without their knowledge. I knowingly and willingly consent to have dental treatment completed, in this office, during the COVID-19 pandemic. \_\_\_\_\_ (Initials)

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date