H & K Orthodontics COVID-19 Patient Screening

This patient treatment 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 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 reschedule treatment after discussing any such conditions with us

It is also important that you disclose to our office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with COVID-19 virus

	YES	NO
Do you have a fever or temperature above 100 F?		
Have you experienced shortness of breath or had trouble breathing?		
Do You have a dry cough?		
Do you have a runny nose?		
Have your recently lost or had a reduction in your sense of smell?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside of USA by airplane or cruise ship in the last 14 days?		
Have you traveled within the USA by airplane, bus, or train in the last 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 are true and accurate.

_____ _____

Patients Name Signature & date (Adult if patient is a minor)