COVID-19 Pandemic 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 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 after discussing any such conditions with us.

It is also important that you disclose to the 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?
		Have your experienced shortness of breath or trouble breathing?
		Do you have a dry cough?
		Do you have a runny nose?
		Have you recently lost or had a reduction in your sense of smell or taste?
		Do you have a sore throat?
		Have you been in contact with someone who has tested positive for COVID19?
		Have you tested positive for COVID-19?
		Have you been tested for COVID-19 and are awaiting results?
		Have you traveled outside the United States by air, bus, train, or cruise ship in the past 14 days?
		Have you traveled within the United States by air, train, or bus or in the past 14 days?
		Have you traveled out of state in the last 14 days?
		Have you been in contact with anyone who traveled out of state in the last 14 days?

Specific Disclosures pertaining to above mentioned questions: _____

_____

_____

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.

Patient Name: _____

Signature of patient, parent or guardian: _____

Date: _____ Time: _____


The Center for
LASER
&
AESTHETIC
MEDICINE