Dr. Neumann, Dr. Dabbert and Dr. Hough

Serenity Dental

WEEPING WATER DENTAL

COVID 19 - PATIENT DISCLOSURE 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.

A weakened or compromised immune system (including but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy and any other 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 the COVID 19 virus.

Do you have a fever or above normal temperature? **Yes** **No**
Have you experienced shortness of breath or had trouble breathing? **Yes** **No**
Do you have a dry cough? **Yes** **No**
Do you have a runny nose? **Yes** **No**
Have you recently lost or had a reduction in your sense of smell? **Yes** **No**
Do you have a sore throat? **Yes** **No**
Have you been in contact with someone who has tested positive for COVID 19? **Yes** **No**
Have you been tested for COVID 19 and are awaiting the results? **Yes** **No**
Have you traveled outside Nebraska in the past 14 days? **Yes** **No**
If so, where? _____

I fully understand and acknowledge the above information, risks and cautions regarding a comprised 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**

1130 Q St, Omaha, NE 68137 (402) 339-6078 healthysmilesNE@gmail.com