Allison Henley DMD
— ALL HEART DENTISTRY —

Patient Name:
Date:

COVID-19 Team Screening and Consent Form

The patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus. This, in conjunction with the Wellness form texted/emailed to you, will help us determine any added risk to you or our staff.

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 condition with us. Please contact Dr. Henley directly if there are any concerns about protocols.

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

Safety is our priority.

	Yes	No
Temperature: _____		
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Do you attest that the answers on your electronic wellness form were truthful and accurate to your knowledge?	☐	☐

Patient Signature: _____

Witness: _____ Date: _____