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COVID-19 PANDEMIC - PATIENT DISCLOSURES

The Center for Disease Control (CDC) has made recommendations in response to the Coronavirus Disease 2019 (COVID-19) outbreak. COVID-19 causes respiratory illnesses ranging from the common cold to severe respiratory distress.
In order to protect you and others, we are asking about symptoms and exposure to COVID-19. Your health and safety is our priority. In addition to continuously disinfecting the office, we have added hospital grade air purifiers for removal of viruses, bacteria and other contaminants for your safety. Your cooperation in filling out the following questionnaire is yet another layer of diligence to protect everyone.

Thank you for you doing your part - Dr. Donald J. Steinberg

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

Do you have or have you had a fever or above normal temperature the last 14 days ..... Yes _____ No _____

Have you experienced shortness of breath or trouble breathing.. Yes _____ No _____

Do you have a dry cough ..... Yes _____ No _____

Do you have a runny nose .....Yes _____ No _____

Have you been in contact with anyone that has had a fever, runny nose, sore throat, cough, difficulty breathing or exposed to COVID-19 .....Yes _____ No _____

Have you recently lost or had a reduction in sense of smell or taste .....Yes _____ No _____

Have you been in contact with someone who has tested positive for COVID-19 .....Yes _____ No _____

Have you tested positive for COVID -19 .....Yes _____ No _____

Have you been tested for COVID-19 and waiting results .....Yes _____ No _____

Have you traveled outside the United States by air or cruise ship in the last 14 days .....Yes _____ No _____

Have you traveled within the United States by air, bus or train within the past 14 days .....Yes _____ No _____

As a patient:

I will come to my appointment alone ……..Yes _____ No _____

I am unable to come alone and my companion is

- Significant other : Name:_____
- sibling : Name:_____
- friend : Name:_____
- neighbor/church member : Name:_____

<u>* Please have your companion fill out this questionnaire also. *</u>

Visitor Policy: Our practice does not allow visitors access to operatories in order to maintain the highest levels of safety and privacy for all patients, staff and doctor.

I fully understand and acknowledge the above information, risk and cautions regarding an office visit and have disclosed to my provider any conditions in my health history and any activities relating to increased risk to COVID-19.

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

_____ _____

Signature Date

_____

Witness