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COVID- 19 Screening Form

Vital Health & Wellness Center
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This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus pandemic.

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 and developing fatal complications. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after disclosing 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 the COVID-19 virus.

Patient Name: _____

	Date: _____
Do you have fever or have you felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a dry cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache, sore throat or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you or have you been in contact with any confirmed or suspicious COVID-19 positive patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you tested positive for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you traveled in the past 14 days to any regions affected by COVID-19? If yes: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Positive responses to any of these would likely indicate a deeper discussion with the orthodontist before proceeding with elective orthodontic treatment. 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 above are true and accurate.

Signature: _____
 by writing your name, it counts as signature

Date: _____