Orange County Pediatric Dentistry
Dr. Dayna Olstein
Dr. Arielle Rolon

COVID-19 Questionnaire

PATIENT INFORMATION

First Name		Last Name		Birth Date	

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 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.

WITHIN THE LAST 14 DAYS, HAVE YOU HAD:	YES	NO
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had 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?		
Do you have a sore throat?		
Are you in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		

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.

FORM COMPLETION

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

Signature of Patient, Parent or Guardian		Date	

IF PATIENT IS A MINOR

Form signed by		Relationship to Patient	
Witness			