NORTHERN ARIZONA PERIODONTICS
Dental Implants & Specialized Gum Care

PATIENT COVID DISCLOSURE

Are you experiencing any of the following symptoms within the last 7 days:

- ☐ Fever or chills
- ☐ Cough
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Fatigue
- ☐ Muscle or body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Allergies
- ☐ None

Record your current temperature:	**Current Temperature** _____
Have you tested positive for or been diagnosed with COVID-19 in the last 14 days?	☐ **No** ☐ **Yes**
Have you been advised to self-quarantine because of exposure to someone who tested positive to Covid-19?	☐ **No** ☐ **Yes**
Have you or someone in your household traveled outside the Arizona or the United States in the past 14 days?	☐ **No** ☐ **Yes**
Have you/household member(s) been in close contact (within 6 feet) with anyone diagnosed with, symptomatic of, or exposed to someone with Covid-19 or Covid-19 like symptoms in the last 14 days?	☐ **No** ☐ **Yes**

If you checked YES for any of the above questions, please explain:

_____

_____

_____

By signing this document I acknowledge that I fully understand/declare . . .

- ☐ **Information in the document is accurate and used to assess COVID-19 risk & in determining treatment needs/safety.**
- ☐ **Individuals older than 65 &/or with weak/compromised immune systems are at great risk for contracting COVID-19.**
- ☐ **If you have been exposed to/are experiencing symptoms of COVID-19, you must notify staff prior to treatment.**
- ☐ **I have disclosed to Northern Arizona Periodontics any medical conditions, symptoms, or recent travel that may be attributed to an increased level of exposure to COVID-19.**

_____ _____
Patient / Patient's Legal Representative | Relationship to Patient

_____ _____ _____
Patient Name (please print) | Birth Date | Today's Date