Nicole E. Pagonis DDS Inc.

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions during the COVID-19 pandemic.

A weakened or compromised immune system (which may be due to underlying conditions like cancer, diabetes, asthma, and COPD; treatments like radiation, chemotherapy, and immunosuppressive drugs; and any prior or current disease or medical condition), can put you at greater risk for contracting COVlD-19. Please disclose to us any condition or treatment/medication that weakens or 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 COVID-19.

PLEASE CIRCLE YES OR NO

Do you have a fever or above normal temperature? YES or NO
Have you experienced shortness of breath or had trouble breathing? YES or NO
Do you have a dry cough? YES or NO
Do you have a runny nose? YES or NO
Have you recently lost or had a reduction in your sense of smell or taste? YES or NO
Do you have a sore throat? YES or NO
Have you been in contact with someone who has tested positive for COVID-19? YES or NO
Have you tested positive for COVID-19? YES or NO
Have you been tested for COVID-19 and are awaiting results? YES or No
Have you traveled outside the United States in the past 14 days? YES or NO
Have you traveled within the United States by air, bus or train within the past 14 days? Yes or No

I fully understand and acknowledge the above information, risks and cautions regarding a weakened or compromised immune system and have disclosed to my provider any conditions in my health history which may result in a weakened or compromised immune system. IT IS MY RESPONSIBILITY TO MAKE DR. PAGONIS and HER TEAM AWARE OF ANY CHANGES TO THE ANSWERS NOTED ABOVE or CHANGES IN MY OVERALL HEALTH, PRIOR TO ANY VISITS. I ALSO UNDERSTAND, I WILL BE SCREENED AT EACH VISIT.

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

Signature _____Date: _____