Mason, Faith & Hoscheit DDS, LTD
2035 Foxfield Road, Suite 103
St. Charles, IL 60174

Covid-19 Patient Disclosures

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 weakened or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and 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.

	Yes	**No**
Do you have a fever or have you felt feverish recently?	☐	☐
Do you have a cough?	☐	☐
Are you having shortness of breath or any difficulty breathing?	☐	☐
Any other flu-like symptoms, such as an upset stomach, sore throat, chills, muscle pain or headache?	☐	☐
Do you have a recent loss of taste or smell?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been in contact with anyone who has been confirmed to be COVID-19 positive?	☐	☐
Do you have any of the following pre-existing medical conditions or concerns about coming into the office for treatment: ● Diabetes ● Heart, Lung, or Kidney Disease ● Cancer Treatment ● Immune weakening medications or conditions	☐	☐

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 Date