COVID-19 Questionnaire and Consent

IF the answer to ANY of these questions is YES, please call our office at 214-823-9652.

Please answer each question and sign, date below.

Have you tested positive for COVID-19?_____

Have you been tested for COVID-19 and are awaiting results?_____

Do you have any of the following respiratory symptoms? Fever, sore throat, cough or shortness of breath?__

Have you recently lost your sense of smell or taste?_____

Do you have any GI symptoms? Diarrhea? Nausea?_____

Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?_____

Have you traveled outside the U.S. by air or cruise ship in the past 14 days?_____

Have you traveled within the U.S. by air, bus or train within the past 14 days?_____

I understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

Fever
Shortness of breath
Dry cough
Runny nose
sore throat

I also acknowledge that I could contract the COVID-19 virus from outside this office, hospital and unrelated to my visit.

I UNDERSTAND THE ABOVE INFORMATION AND AGREE WITH ITS CONTENTS.

_____

Patient or Person to Sign for Patient Date/Time

Witness_____Date/Time_____