Self-disclosure COVID-19 (Coronavirus SARS-CoV-2)

Name, first name: ______________________ Date of birth: ______________

Adress: ______________________ Phone: ______________

Are you or any family members living in the same household currently in a quarantine ordered by the public health department

- ☐ No
- ☐ Yes, myself in the following period: ______________
- ☐ Yes, one member in the following period: ______________

Are you sick?

- ☐ No
- ☐ Yes, I suffer from: ☐ sore throat ☐ coughing ☐ high temperature ☐ sniffles ☐ breathing difficulties ☐ tastelessness and odorless

Which statement applies to you?

- ☐ Fully vaccinated against COVID-19 (last vacc.more than 14 days ago)
- ☐ Recovered from COVID-19 Disease period (month/year): ______________
- ☐ Negative tested Date of the test: ______________ Performed by: ______________
- ☐ Positive tested Date of the test: ______________ Performed by: ______________

Do one or more of these following risk factors apply to you?

- ☐ Cardiovascular diseases
- ☐ Lung diseases (f. ex. asthma, chronic bronchitis)
- ☐ Chronic liver- or kidney disease
- ☐ Diabetes
- ☐ Oncological patient (chemotherapy)
- ☐ Immunosuppressed patient due to illness or therapy

All information are voluntary. I confirm the correctness of my statements. Should changes occur during the entire treatment period, I will inform the dental surgery immediately.

______________________ ______________________

Place/date Signature patient

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