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