Woodbridge
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COVID-19 PATIENT SCREENING

Please print and complete this survey no earlier than 24 hours prior to your appointment. Bring the completed survey to your appointment and give to the receptionist upon check-in.

Have you or anyone in your household had a temperature of 100 degrees or higher in the last 24 hours?	**YES** OR NO (CIRCLE ONE)
Do you or anyone in your household have any of the following symptoms: • Runny nose • Congestion • Sore throat • Cough • Shortness of breath/difficulty breathing • Vomiting/diarrhea/abdominal pain • New onset of headache • New loss of smell and/or taste	**YES** OR NO (CIRCLE ONE)
In the past 14 days have you or anyone in your household been in contact for more than 10 minutes and within 6 feet of someone who tested positive for COVID-19?	**YES** OR NO (CIRCLE ONE)
Have you traveled on a plane in the past 14 days?	**YES** OR NO (CIRCLE ONE)
If you were tested for COVID-19 within the past 10 days, what date was the test performed? _____.	Test Results: ___**POSITIVE** ___**PENDING** ___NEGATIVE

If you answered YES to any of these questions *and/or* have a POSITIVE or PENDING COVID-19 TEST RESULT your appointment will be rescheduled as a virtual visit. Please call the office at 732-634-0036 and press **prompt 1** to speak to the scheduling department.

If you answered NO to ALL of these questions please hand this screening to the receptionist along with your insurance card and photo ID for a faster check-in.

_____ _____
Printed Name Date of Birth

_____ _____
Signature Today's Date