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COVID-19 PATIENT SCREENING FORM

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

Patient Name:	**Pre-Appt**		**In Office**	
Do you/they have fever or have you/they felt hot or feverish Recently (14-21 days)?	Yes	No	Yes	No
Are you/they having shortness of breath or other difficulties breathing?	Yes	No	Yes	No
Do you/they have a cough?	Yes	No	Yes	No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes	No	Yes	No
Have you/they experienced recent loss of taste or smell?	Yes	No	Yes	No
Are you/they in contact with any confirmed COVID-19 positive patients? (Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.)	Yes	No	Yes	No
Is your/their age over 60?	Yes	No	Yes	No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes	No	Yes	No

Have you/they traveled in the past 14 days to any

regions affected by COVID-19? (as relevant to your location) Yes No Yes No

If you experience any symptoms that might suggest you have COVID-19 or you are diagnosed with COVID-19 from the time of your appointment up to 14 days after your appointment, it is your responsibility to let our office know.

Patient Signature:____

Date:____