Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	**IN-OFFICE**
	Date:	Date:
Do you have fever or have you/they felt hot or feverish recently (last 14 days)?	❑ Yes ❑ No	❑ Yes ❑ No
Are you having shortness of breath or other difficulties breathing?	❑ Yes ❑ No	❑ Yes ❑ No
Do you 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 experienced recent loss of taste or smell?	❑ Yes ❑ No	❑ Yes ❑ No
Are you 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 age over 60?	❑ Yes ❑ No	❑ Yes ❑ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	❑ Yes ❑ No	❑ Yes ❑ No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	❑ Yes ❑ No	❑ Yes ❑ No

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

- For testing, see the list of State Health Department Websites for your specific area's information.