Patient Screening Form

PLEASE REMIND PATIENT TO WEAR MASK TO APPOINTMENT

Patient Name		
	Pre- Appointment	In- Office
	Date:	Date:
Do you/they have a fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
In office Temperature @ time of check in	n/a	
Are you/they having shortness of breath or other difficulites breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a dry cough?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a runny nose?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a sore throat?	☐ 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 relavent 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 and Territorial Health Department Websites for your specific area's information.