***Patient Screening Form***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | **Pre-Appointment:** | **In-Office:** |
|  | **Date:** | **Date:** |
| Do you have a cough? | Yes \_\_\_\_ No\_\_\_\_\_ | Yes \_\_\_\_ No\_\_\_\_\_ |
| Are you having any shortness of breath? | 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\_\_\_\_\_ |
| Do you have heart, lung, kidney disease, diabetes or any auto-immune disorders? | Yes \_\_\_\_ No\_\_\_\_\_ | Yes \_\_\_\_ No\_\_\_\_\_ |
| Are you over the age of 60? | 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\_\_\_\_\_ |
| Are you or have you been 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\_\_\_\_\_ |
| Do you have a fever or have you felt hot or feverish recently or in the last 14-21 days?  | Yes \_\_\_\_ No\_\_\_\_\_ | Yes \_\_\_\_ No\_\_\_\_\_ |

Temperature in office: \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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