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PATIENT SCREENING FORM

Patient Name:	Pre-appointment Date:		In office Date:	
1)Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes____	No____	Yes___	No___
2)Are you/they having shortness of breath or other difficulties breathing?	Yes____	No_____	Yes____	No___
3)Do you/they have a cough?	Yes___	No______	Yes____	No__
4)Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes____	No_____	Yes____	No__
5)Have you/they experienced recent loss of taste or smell?	Yes____	No_____	Yes___	No__
6)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___
7) Is your/their age over 60?	Yes____	No____	Yes___	No__
8)Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes____	No____	Yes___	No__
9) Have you/they traveled in the past 14 days to any 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 and Territorial Health Department Websites for your specific area's information.