COVID-19 Patient Screening Form

Patient Name: Age:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you have a fever or have you felt feverish recently?	☐ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath, other difficulties breathing or a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have 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
Have you been tested for COVID-19 or had an antibody test?	☐ 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
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled outside the US by air or cruise ship in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled within the US by air, bus or train within the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

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