Patient Screening Form

Patient Name:

	PRE-APPOINTMENT		IN-OFFICE	
	Date:		Date:	
Do you have a fever or have you felt hot or feverish recently? (14-21 days)	Yes	No	Yes	No
Are you having shortness of breath or other difficulties breathing?	Yes	No	Yes	No
Do you have a cough or sore throat?	Yes	No	Yes	No
Any other flu-like symptoms, such as gastrointestinal upset, headache, chills, muscle aches or fatigue?	Yes	No	Yes	No
Have you experienced recent loss of taste or smell?	Yes	No	Yes	No
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 will be rescheduled for routine or 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 in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes	No	Yes	No

If yes to the questions above, please specify:

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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.