Patient Screening Form

Patient Name: Date: Date:

	Pre-appointment		In-Office
Do you/they have a fever or felt hot or feverish lately? (14-21 days)	Yes [] No []		Yes [] No []
Are you/they having shortness of breath or other difficulties breathing?	Yes [] No []		Yes [] No []
Do you/they have 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/they experienced any 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 have a sick family member at home with Covid-19 should consider postponing elective treatment.*	Yes [] No []		Yes [] No []
Are you/they over the age of 60?	Yes [] No []		Yes [] No []
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any autoimmune disorders?	Yes [] No []		Yes [] No []
Have you/they traveled in the last 14 days to any regions affected by Covid-19? (as relevant to your location)	Yes [] No []		Yes [] No []

Positive responses to any of these questions 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.

Dentist Signature: ____ Date:__________________________________