Patient/Visitor COVID-19 Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE	48-HOURS POST APPOINTMENT
	Date:	Date:	Date:
Do you have fever or have you felt hot or feverish in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache, chills, fatigue, runny nose, or sore throat?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you experienced a recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you tested positive for COVID-19 or are you awaiting results from a pending COVID-19 test?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been in contact with any confirmed COVID-19 positive patients in the past 14 days? (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	☐ Yes ☐ No
Are you over 60?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled in the past 14 days by bus, commercial airline, or train?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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