## **Patient Screening Form**

## **Patient Name:**

	PRE-APPOINTMENT		IN-OFFICE	
	Date:		Date:	
Do you/they have fever or have you/they felt hot or feverish recently (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
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	□Yes	□No	□Yes	□No
Have you/they experienced recent 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 who have a sick family member at home with COVID-19 should consider postponing elective treatment.	□Yes	□No	□Yes	□No
Is your/their age over 60?	□Yes	□No	□Yes	□No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	□Yes	□No	□Yes	□No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	□Yes	□No	<i>□</i> 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 <u>State and Territorial Health Department Websites</u> for your specific area's information.