

## **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      | ☐ 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 State and Territorial Health Department Websites for your specific area's information.