

Patient Screening Form



IN-OFFICE	
Patient Name:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Please limit extra companions on your trip to the office to help reduce the number of people in the reception area. We understand this may not be possible, however we appreciate you doing what is reasonable to keep crowding down for the time being.

Patient/guardian signature

Date