Pre-Appointment Screening Form

Today's Date: _____

Patient Name: _____ **Responsible Party Name:** _____

Please print all information clearly.

	Date_____		Date _____	
	Yes	**No**	**Yes**	**No**
Do you/they have fever or have you/they felt hot or feverish recently?	☐	☐	☐	☐
Are you/they having shortness of breath or other difficulties breathing?	☐	☐	☐	☐
Do you/they have a cough?	☐	☐	☐	☐
Do you/they have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐	☐	☐	☐
Have you/they experienced recent loss of taste or smell?	☐	☐	☐	☐
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)

Is your/their age over 60?	☐	☐	☐	☐
Do you/they have heart disease, kidney disease, diabetes or any auto-immune disorder?	☐	☐	☐	☐
Have you/they traveled in the past 14 days to any regions affected by COVID-19?	☐	☐	☐	☐
Assistant/FD signatures:	_____		_____	

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

For testing, see the list of "State and Territorial Health Department Websites" for your specific area's information.

Please contact our office if you develop any symptoms within 14 days of your appointment.

Patient/responsible party signature below Temperature: _____ Date: _____ Initial: _____