COVID-19 Patient Screening Form

Patient Name_____

1) Has the patient experienced any flu-like symptoms in the past 72 hours:
□ Yes □ No

If yes, which:

_____ Fever
_____ Chills
_____ Muscle aches
_____ Runny nose
_____ Abdominal pain and/or diarrhea
_____ Loss of sense of taste or smell
_____ Sore Throat
_____ Shortness of breath
_____ Nausea/Vomiting
_____ Headache
_____ Cough

2) Is the patient currently awaiting test results for Covid19? □ Yes □ No

3) Has the patient been in close contact with someone who has been ill with cough and/or fever within the past 14 days? □ Yes □ No

4) Does the patient have any of the following conditions:

_____ Heart condition
_____ Lung condition
_____ Immune compromised (HIV, cancer, other)
_____ High Blood Pressure
_____ Diabetes
_____ Pregnant

5) Current patient temperature _____

I agree to inform this office if I develop symptoms or are diagnosed with COVID-19 within 2 days following the dental appointment.

I have interviewed the patient and confirm that they are approved to receive dental treatment.

_____
Employee Signature

_____
Employee Name

_____
Date

I certify that all information provided above is true and correct and I consent to receive treatment

_____
Patient Signature

_____
Patient Name

_____
Date