

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

- 2) Have you been in close contact with someone who has been ill with cough and/or fever within the past 14 days?
 Yes No

- 3) Do you have any of the following conditions:

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

- 4) 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.

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

Employee Signature

Patient Signature

Employee Name

Patient Name

Date

Date