Patient Full Name: ____________________________________

COVID-19 Questionnaire

Instructions: Please review the questions below. If you answer yes to any of the questions, we may reappoint you for a later date.

Have you had contact with anyone confirmed positive for COVID-19 in the last 14 days? (Note: A fully vaccinated individual who has been in close contact with someone confirmed with COVID-19 can enter the practice and have dental treatment completed).	Y | N

Are you waiting for COVID-19 test results?	Y | N

In the past 14 days, have you had symptoms that include:	
Fever over 100.0°F or chills	Y | N
Shortness of breath or difficulty breathing	Y | N
Cough	Y | N
Congestion or runny nose	Y | N
Headache	Y | N
Fatigue	Y | N
Nausea or vomiting	Y | N
Diarrhea	Y | N
New loss of taste or smell	Y | N
Sore throat	Y | N
Muscle or body aches	Y | N

Does the patient have a latex allergy?	Y | N

PROVIDER NOTE: Actively take temperature of anyone entering the practice. Recording of temperatures is not necessary.