



PATIENT SCREENING FORM

Patient Name: _____

	PRE-APPOINTMENT	IN-OFFICE
	Date: _____	Date: _____
Have you been diagnosed with, or treated for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<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	<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.

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.

_____ Signature Temperature _____