Patient Screening Form for COVID-19

Name: _____

Date: _____

	Before Appointment	At Office
	Date: _____	Date: _____
Do you/they have fever or have you/they felt hot or feverish recently (past 14-21 days)?	▫ Yes ▫ No	▫ Yes ▫ No
Are you having shortness of breath or other difficulties breathing?	▫ Yes ▫ No	▫ Yes ▫ No
Do you/they have a cough?	▫ Yes ▫ No	▫ Yes ▫ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	▫ Yes ▫ No	▫ Yes ▫ No
Have you/they experienced recent loss of taste or smell?	▫ Yes ▫ No	▫ Yes ▫ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	▫ Yes ▫ No	▫ Yes ▫ No
Is your/their age over 60?	▫ Yes ▫ No	▫ Yes ▫ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	▫ Yes ▫ No	▫ Yes ▫ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	▫ Yes ▫ No	▫ Yes ▫ 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.