

Patient Screening Form

Patient Name: _____

Date: _____

Date: _____

	Pre-appointment		In-Office
Do you/they have a fever or felt hot or feverish lately? (14-21 days)	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you/they having shortness of breath or other difficulties breathing?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you/they have a cough?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you/they experienced any loss of taste or smell?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you/they in contact with any confirmed Covid-19 positive patients? <i>Patients who are well but have a sick family member at home with Covid-19 should consider postponing elective treatment.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you/they over the age of 60?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any autoimmune disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you/they traveled in the last 14 days to any regions affected by Covid-19? (as relevant to your location)	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Positive responses to any of these questions 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: _____

Date: _____