

Patient Screening Form

	PRE-APPOINTMENT	IN-OFFICE
Please use an "X" to mark your answers to the following questions.	Date: ____/____/____	Date: ____/____/____
1. Do you/the patient have fever or have you/the patient felt hot or feverish recently (14–21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you/the patient having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you/the patient have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
4. Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you/the patient experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
6. Are you/the patient 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>	☐ Yes ☐ No	☐ Yes ☐ No
7. Is your/the patient's age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
8. Do you/the patient have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you/the patient traveled in the past 14 days?	☐ 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 Centers for Disease Control and Prevention (CDC)'s list of State and Territorial Health Department Websites for your specific area's information: <https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html>.