COVID-19 Patient Screening Form

Patient and Accompanying Guardian Information

Last Name: _____ First Name: _____ Birthdate: _____

Guardian Name: _____

	PRE-APPOINTMENT Date:	IN-OFFICE Date:
1) Does the patient or accompanying guardian have fever or have you/they felt hot or feverish recently (14-21 days)?	Select Yes / No	Select Yes / No
2) Are the patient or accompanying guardian having shortness of breath or other difficulties breathing?	Select Yes / No	Select Yes / No
3) Do the patient or accompanying guardian have a cough?	Select Yes / No	Select Yes / No
4) Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Select Yes / No	Select Yes / No
5) Have the patient or accompanying guardian experienced recent loss of taste or smell?	Select Yes / No	Select Yes / No
6) Are the patient or accompanying guardian 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	Select Yes / No	Select Yes / No
7) Is the accompanying guardian over 60?	Select Yes / No	Select Yes / No
8) Do the patient or accompanying guardian have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Select Yes / No	Select Yes / No
9) Have the patient or accompanying guardian traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Select Yes / No	Select Yes / No

Document any comments and/or concerns if Yes was answered above.

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. https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html.