Patient Screening Form

Patient Name: _____ **Staff:**_____ **Staff:**_____

Date:_____ **Date :**_____

Do you have a fever or feel feverish?	Yes No	Yes No
Are you having shortness of breath or difficulty breathing?	Yes No	Yes No
Do you have a cough?	Yes No	Yes No
Do you have a sore throat?	Yes No	Yes No
Do you have any flu like symptoms such as GI upset, headache, fatigue, or chills?	Yes No	Yes No
Have you experienced a recent loss of taste or smell?	Yes No	Yes No
Have you been in contact with any confirmed COVID-19 positive patients in the past 14 days?	Yes No	Yes No
Are you over 65 years old?	Yes No	Yes No
Do you have heart disease, lung disease, liver disease, Kidney disease, diabetes, or any auto-immune disorder?	Yes No	Yes No
Have you traveled to any region affected by COVID-19 in the past 14 days?	Yes No	Yes No

Temperature:_____ Date:_____

I understand that there may be risks in being in proximity of dentists, patients or staff and in receiving dental treatment. I am aware that COVID-19 is an extremely contagious disease that can lead to severe illness and death. I knowingly and willingly consent to have dental treatment done during the COVID-19 pandemic and I voluntarily assume all risks related to COVID-19.

Patient Sign::_____ Date:_____

Guardian Sign:_____ Date:_____