Patient Screening Form

Patient Name:

	Upon scheduling or confirmation if appt is within 48hrs	In-office
	Date:	Date:
Have you had a fever in the last week? Temperature at appointment: _____ _____ _____	YES / NO	YES / NO
Are you short of breath?	YES / NO	YES / NO
Do you have a cough?	YES / NO	YES / NO
Are you experiencing any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	YES / NO	YES / NO
Have you experienced recent loss of taste or smell?	YES / NO	YES / NO
Have you been in contact with any confirmed cases of COVID-19 in the past 2 weeks?	YES / NO	YES / NO

If the patient answers “Yes” to any of the above questions, or has a repeated temperature of 100.4, the patient should be rescheduled. Questionable responses or situations with a patient's status should be consulted with the dentist on duty.