COVID-19 Screening Questionnaire

Patient Name:

In following both CDC and ADA recommendations, this questionnaire is designed with your safety in mind. Your answers will be reviewed prior to your appointment before entering the facility, and a member of our team will contact you if we recommend scheduling to a later date. Thank you for your consideration and understanding.

Do you have a fever AND respiratory symptoms like cough or shortness of breath?

No

Yes

Have you had a close contact with a person infected with COVID-19 or history of travel to an affected area?

No

Yes

Are you having difficulty breathing, unable to eat or drink, or too weak to care for yourself?

No

Yes

Is there anything else our team should know before treating you?

_____

_____

_____

_____

_____

_____