COVID-19 Patient Screening Form

Patient Name: Appointment Date:

SCREENING QUESTIONS	Pre-Appt DATE	In-Office Appt DATE	NOTES
Do you have a fever or above-normal temperature (greater than 100.4°F)?	☐ No ☐ Yes	☐ No ☐ Yes	If you answer “yes” to either question on shortness of breath or coughing, or answer “yes” to any combination of two other symptoms and you do not need emergency care, consider rescheduling until symptoms resolve or you can provide proof you are not infectious for COVID-19. The doctor may want to seek additional information from you regarding symptoms.
Are you experiencing shortness of breath or having trouble breathing?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a dry cough?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a runny nose?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a sore throat?	☐ No ☐ Yes	☐ No ☐ Yes	
Are you experiencing chills or repeated shaking with chills?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have unexplained muscle pain?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a headache?	☐ No ☐ Yes	☐ No ☐ Yes	
Even if you don’t have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	If “yes”, and you do not need emergency care, consider rescheduling after 7 days since symptoms first appeared and 3 days of no fever without the use of fever-reducing medication.
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ No ☐ Yes If yes, Date:	☐ No ☐ Yes If yes, Date:	If yes, please provide the date of last contact with COVID-19 positive patient. We will need to reschedule your appointment time for 14 or more days after, unless you need emergency care.
Have you been tested for COVID-19 in the last 14 days? *If “no”, skip to the last question.*	☐ No ☐ Yes	☐ No ☐ Yes	
What is the result of the testing? *If you are still waiting on results, reschedule your appointment after your results are known.*	☐ Negative ☐ Positive	☐ Negative ☐ Positive	If “positive”, and you do not have an emergency, we will need to reschedule your appointment after it has been more than 7 days since symptoms first appeared.
Have you traveled more than 100 miles from your home in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	If “yes”, and you did not follow physical distancing precautions or wear a mask while in public, we may determine whether to proceed with the appointment.

Patient or Parent's signature required at appointment: I agree to notify the dental practice within 14 days if I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the practice has a legal and ethical obligation ***to inform me if a*** *staff person has tested positive for COVID-19* ***within 14*** *days.*

Patient or Parent's Signature____