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Covid - 19 Patient Screening Form

Date: _____

Patient: _____ Temperature: _____

Parent/Guardian: _____ Temperature: _____

Screening Question's	Patient	Parent
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 currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes

Have you been tested for COVID-19 in the last 14 days? If "no" proceed to the next question.	☐ No ☐ Yes	☐ No ☐ Yes
If yes, what is the result of the testing? **If negative**, proceed to the next question. **If still waiting on results**, schedule an appointment after results are known.	☐ Negative ☐ Unsure ☐ Yes	☐ Negative ☐ Unsure ☐ Yes
Have you traveled more than 100 miles from your home in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes

Patient/Parent signature required at appointment:

I agree to notify the dental practice if within 14 days I or my child(ren) becomes ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation\to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in our health and/or medication. Further, I will not hold my dentist, or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form, because risks of infection are everywhere.

_____	_____	_____	_____
(Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date