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COVID - 19 Patient Screening Form

Date: ____________________

Patient: ____ Temperature: ______________

Parent/Guardian: ____ Temperature: ______________

Screening Question's	Patient	Parent
Are you experiencing any of the following symptoms: shortness of breath, dry cough, sore throat, unexplained muscle soreness, headache or nausea, or new loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ Yes ☐ No	☐ Yes ☐ No
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ Yes ☐ No	☐ Yes ☐ No
Have you been tested for COVID-19 in the last 14 days? If "no" proceed to the next question. **If yes**, what is the result of the testing? **If negative**, proceed to the next question. **If still waiting on results**, schedule appointment after results are known.	☐ Yes ☐ No ☐ Negative ☐ Positive ☐ Unsure	☐ Yes ☐ No ☐ Negative ☐ Positive ☐ Unsure
Have you traveled out of state or out of country in the last 14 days? **If yes**, please specify where? Did you travel by car or plane?	☐ Yes ☐ No	☐ Yes ☐ No
Are you fully vaccinated for COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No

Patient/Parent signature required at appointment:

I agree to notify the dental practice if within 2 days I or my child(ren) become 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 2 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