Patient Screening Form

Patient Name: **Age:** **Appt Date:**

Screening Questions	Date: / / Staff Initials:	Date: / / Staff Initials:
**** Do you/they have now or have you/they had a fever above 100.4^{o} in the last 14 days? **Take temperature at appointment. Record Temp:**	□ Yes □ No	□ Yes □ No
**** Have you/they been in contact with any confirmed COVID-19 positive patient in the last 14 days?	□ Yes □ No	□ Yes □ No
**** Have you/they been tested for COVID-19 in the last 14 days? Results: □ Negative □ Positive □ Still waiting for results	□ Yes □ No	□ Yes □ No
Do you/they have (circle all that apply) •Heart disease •Lung disease •Kidney disease • Diabetes •Any auto-immune disorders?	□ Yes □ No	□ Yes □ No
Do you/they have or have you/they had in the last 14 days (circle all that apply) •Shortness of breath •Dry cough •Runny nose •Sore throat •Seasonal Allergies •Muscle pain •Headache •Unusual fatigue •Gastrointestinal upset •Loss of sense of smell or taste	□ Yes □ No	□ Yes □ No
Have you/they taken acetaminophen, ibuprofen, aspirin or other nsaid medication in the last 14 days? Why:	□ Yes □ No	□ Yes □ No
Have you/they traveled more than 100 miles from home in the last 14 days?	□ Yes □ No	□ Yes □ No
Have you/they attended any large group functions in the last 14 days? If yes; Did you practice Social Distancing?	□ Yes □ No □ Yes □ No	□ Yes □ No □ Yes □ No

Patient/Parent/Guardian Signature at appointment: I agree to notify the dental practice if within 14 days I 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 doctor or staff person I had contact with tested positive of COVID-19 within 14 days.

Signature: _____

**** Reschedule the appointment 21 days from the day of positive response or positive test