



Patient Screening Form

Patient/Parent/Guardian Names: _____ Temperature: _____

Screening questions	PRE-APPOINTMENT	IN-OFFICE
	Date: Staff initial: ____	Date: Staff initial: ____
Do you have a fever or above-normal temperature (>100.4° F)? <i>Take temperature at appointment.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you experiencing shortness of breath or having trouble breathing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a dry cough?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a runny nose?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you recently lost or had a reduction in your sense of smell or taste?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a sore throat?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you experiencing chills or repeated shaking with chills?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have unexplained muscle pain?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a headache?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Screening questions	PRE-APPOINTMENT	IN-OFFICE
	Date: Staff initial: ____	Date: Staff initial: ____
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you been tested for COVID-19 in the last 14 days? <i>If "no," proceed to next question.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, what is the result of the testing?</i>	<input type="checkbox"/> No	<input type="checkbox"/> No
<i>If negative, proceed to next question.</i>	<input type="checkbox"/> Unsure	<input type="checkbox"/> Unsure
<i>If still waiting on results, schedule appointment after results are known.</i>	<input type="checkbox"/> Positive	<input type="checkbox"/> Positive
Have you traveled more than 100 miles from your home in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Patient signature required 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 staff person I had contact with tested positive for COVID-19 within 14 days.

Signature _____