

# Patient Screening Form

Patient Name:

|                                                                                                                                                                                                               | PRE-APPOINTMENT                                          | IN-OFFICE                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
|                                                                                                                                                                                                               | Date:                                                    | Date:                                                    |
| Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you/they having shortness of breath or other difficulties breathing?                                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you/they have a cough?                                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?                                                                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you/they experienced recent loss of taste or smell?                                                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you/they in contact with any confirmed COVID-19 positive patients?<br><i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is your/their age over 60?                                                                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.