PATIENT SCREENING FORM

Patient Name: ______________________________ Temperature:_______

Do you or those you live with have a fever, or have any of you felt hot or feverish recently (in the last 14 days)?	Yes ☐	No ☐
Are you or those you live with experiencing shortness of breath or other difficulties breathing?	Yes ☐	No ☐
Do you or those you live with have a cough?	Yes ☐	No ☐
Are you or those you live with experiencing any other flu-like symptoms, such as gastro-intestinal upset, headache, or fatigue?	Yes ☐	No ☐
Have you or those you live with experienced a recent loss of taste or smell?	Yes ☐	No ☐
Are you or those you live with in contact with any confirmed COVID-19 positive patients?	Yes ☐	No ☐
Do you or those you live with have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	Yes ☐	No ☐

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