COVID 19 Screening Form

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This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19 and developing fatal complications. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

Patient Name:_______________________________________

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you have fever or have you felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have a dry cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache, sore throat or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you or have you been in contact with any confirmed or suspicious COVID-19 positive patients?	☐ Yes ☐ No	☐ Yes ☐ No
Have you tested positive for COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled in the past 14 days to any regions affected by COVID-19? If yes: ____________________________	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment. I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature: ________________________________ **Date**:__________________________
by writing your name, it counts as signature