COVID-19 Screening Form
Adapted from the ADA

Patient Name: _____

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

	Pre-Appointment	In Office
	Date:	Date:
Do you/they have a fever or have you/they felt hot or feverish recently (14-21 days)?	☐Yes ☐No	☐Yes ☐No
Are you/they having shortness of breath or other difficulties breathing?	☐Yes ☐No	☐Yes ☐No
Do you/they have a cough?	☐Yes ☐No	☐Yes ☐No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐Yes ☐No	☐Yes ☐No
Have you/they experienced recent loss of taste or smell?	☐Yes ☐No	☐Yes ☐No
Are you/they in contact with any confirmed COVID-19 positive patients, or been instructed to be in self isolation? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	☐Yes ☐No	☐Yes ☐No
Is your/their age over 60?	☐Yes ☐No	☐Yes ☐No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐Yes ☐No	☐Yes ☐No

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold of flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at the gym, store, or restaurant. "Social Distancing" nationwide has reduced the transmission of COVID-19. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing at all times.

By signing below, I attest that, to the best of my knowledge and belief, the above responses are accurate. Furthermore, I accept the risks and consent to treatment.

_____ _____

Patient/Parent's/Guardian's Signature Date