# Patient Screening Form

Temp:_____

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

**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.