COVID-19 Patient Screening Form

Patient Name____

- Has the patient (or someone they live with) returned from travel to a non-U.S. country in the previous 30 days?

  Yes No

  If yes, please name the country/countries visited

  ____

- Have you been exposed, recovered from, or tested positive to COVID-19?

  Yes No

  If yes, which (check all that apply):

  ________ Exposed
  ________ Recovered from
  ________ Tested Positive

- Do you live with someone who has been exposed or has tested positive for COVID-19?

  Yes No

- Is the patient currently experiencing any of the following flu-like symptoms:

  Yes No

  If yes, which:

  ________ Fever
  ________ Chills
  ________ Muscle aches
  ________ Runny nose
  ________ Abdominal pain and/or diarrhea
  ________ Loss of sense of taste or smell
  ________ Sore Throat
  ________ Shortness of breath
  ________ Nausea/Vomiting
  ________ Headache
  ________ Cough
  ________ Diarrhea

- Have you been in close contact with someone who has been ill with cough and/or fever within the past 14 days?

  Yes No

- Do you have any of the following COVID-19 health risk factors:

  ________ Over 65
  ________ Lung condition
  ________ Immune compromised (HIV, cancer, other)
  ________ Heart condition
  ________ High Blood Pressure
  ________ Diabetes
  ________ Pregnant

- Current patient temperature ____

I have interviewed the patient and confirm that they are approved to receive dental treatment.

Employee Signature____

Employee Name ____

Date____