

Patient/Parent/Guardian Names: _____

Screening Questions	Date: ___/___/___ Staff Initial: _____	Date: ___/___/___ Staff Initial: _____	Notes
Do you have a fever or above-normal temperature (>100.4°F)? <i>Take temperature at appointment.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Are you experiencing shortness of breath or having trouble breathing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a dry cough?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a runny nose?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a sore throat?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Are you experiencing chills or repeated shaking with chills?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have unexplained muscle pain?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a headache?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Screening Questions	Date: __/__/____ Staff Initial: _____	Date: __/__/____ Staff Initial: _____	Notes
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you been tested for COVID-19 in the last 14 days? <i>If "no", proceed to the next question.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>If yes, what is the result of testing?</i> <i>If negative, proceed to the next question.</i> <i>If still waiting on results, schedule an appointment after results are known.</i>	<input type="checkbox"/> Negative <input type="checkbox"/> Unsure <input type="checkbox"/> Positive	<input type="checkbox"/> Negative <input type="checkbox"/> Unsure <input type="checkbox"/> Positive	
Have you traveled more than 100 miles from your home in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Patient signature required at appointment:

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature: _____