**PATIENT SCREENING FORM**

This form is in accordance with ADA and CDC guidelines to screen and protect patients against COVID-19.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following questions must be filled out by the child’s legal guardian or the patient if over age 18.

|  |  |  |
| --- | --- | --- |
|  | **Pre-Appointment** | **In-Office** |
| Do you/your child have fever or have felt hot or feverish in the last 14 days? |  Yes  No |  Yes  No |
| Are you/your child having shortness of breath or other difficulties breathing? |  Yes  No |  Yes  No |
| Do you/your child have a cough? |  Yes  No |  Yes  No |
| Any other flu-like symptoms such as: gastrointestinal upset (diarrhea/nausea), headache, fatigue, or abdominal (stomach) pain? |  Yes  No |  Yes  No |
| Have you/your child experienced recent loss of taste or smell? |  Yes  No |  Yes  No |
| Have you/your child been in contact with any SUSPECTED OR CONFIRMED POSITIVE COVID-19 patients within the last 14 days? |  Yes  No |  Yes  No |
| Do you/your child have any history of heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders leaving them at higher risk of severe infection from coronavirus? |  Yes  No |  Yes  No |
| Have you/your child traveled in the past 14 days by bus, train, plane, or public transport?  |  Yes  No |  Yes  No |
| Have you/your child traveled in the past 14 days to any regions affected by COVID-19?  |  Yes  No |  Yes  No |

If you select “yes” on any of the above responses, please inform our dental staff so we can engage in further discussion before you/your child enters the office today.

I certify all of the above information is complete and truthful.

Signature of Parent/Guardian/Patient if over age 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_