NAME:_________________________AGE_____PRE-APP DATE:________IN-OFFICE DATE_______

HAVE YOU TESTED POSITIVE FOR COVID-19? YES________ NO______
If yes, date of diagnosis and location:____

HAVE YOU RECEIVED A NEGATIVE TEST RESULT SINCE DIAGNOSIS? YES________ NO_______
If yes, date of negative test result:__________________________

HAVE YOU HAD AN ANTIBODY TEST? YES________ NO_______
What was the results of the antibody test:___________________

ARE YOU IN CONTACT WITH ANY CONFIRMED COVID-19 POSITIVE PATIENTS? YES________ NO_______

DO YOU HAVE A FEVER OR HAVE FELT FEVERISH RECENTLY? YES________ NO_______

ARE YOU HAVING SHORTNESS OF BREATH, DIFFICULTIES BREATHING OR A COUGH? YES________ NO_______

<u>DO YOU HAVE ANY FLU- LIKE SYMPTOMS SUCH AS:</u>

HEADACHE, FATIGUE GASTROINTESTIONAL OR UPSET STOMACH YES_______ NO_______

HAVE YOU EXPERIENCED RECENT LOSS OF TASTE/SMELL? YES_______ NO_______

<u>DO YOU HAVE THE FOLLOWING:</u>

LUNG DISEASE YES_______ NO_______

KIDNEY DISEASE/DIABETES YES_______ NO_______

HEART DISEASE YES_______ NO_______

AUTO-IMMUNE DISORDER YES_______ NO_______

HAVE YOU TRAVELED OUTSIDE THE US BY AIR IN THE PAST 14 DAYS? YES_______ NO_______

IF YES, WHAT ARE THE TRAVEL DATES:_______________________________

HAVE YOU TRAVELED WITHIN THE US BY AIR: YES_______ NO_______

IF YES, WHAT ARE THE TRAVEL DATES:_______________________________

COVID-19 PATIENT SCREENING FORM

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