Patient Screening Form

Name :

		IN-OFFICE
Temperature:		Date:
Have you had a fever in the last 14 days?		☐ Yes No ☐
Are you having shortness of breath or difficulty breathing?		☐ Yes No ☐
Do you have a cough?		☐ Yes No ☐
Any other flu-like symptoms, such as headache or fatigue?		☐ Yes No ☐
Have you experienced recent loss of taste or smell?		☐ Yes No ☐
Are you in contact with anyone confirmed with COVID-19?		☐ Yes No ☐
Have you received any of the COVID vaccines?		☐ **Yes** **No** ☐ ☐ **First Dose**

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