Patient Screening Form

Patient's Name:_____

Screening questions	Date:
Are you fully vaccinated for COVID-19?	☐ No ☐ Yes
Do you have a fever or above normal temperature (>100.0。F)?	☐ No ☐ Yes
Are you experiencing more than one of the following symptoms: shortness of breath, dry cough, sore throat, unexplained muscle pain, headache or nausea, new loss of taste or smell?	☐ No ☐ Yes
Even if you don't currently have any of the above symptoms, have you experienced morethan one of these symptoms in the last 14 days?	☐ No ☐ Yes
Have you been advised to quarantine due to close contact with someone diagnosed with COVID-19?	☐ No ☐ Yes
Have you been tested for COVID-19 in the last 14 days? *If "no," proceed to next question.* ***If yes**, what is the result of the testing?* ***If negative,** proceed to next question.* ***If still waiting on results,** scheduleappointment after results are known.*	☐ No ☐ Yes ☐ No ☐ Unsure ☐ Positive
Have you traveled out of state or out of country in the last 14 days?	☐ No ☐ Yes

I agree to notify the dental practice if within 2 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 close contact with tested positive for COVID-19 within 2 days.

Signature_____