DENTAL PATIENT SCREENING FORM

To reduce the risk of spreading COVID-19, we ask you to please answer the screening questions below. For the safety of yourself, other patients, and our dedicated staff, please be truthful and candid in your answers.

All patients in this dental office must complete this form by checking any boxes that apply.

☐ **Do you currently have a fever (≥100.4), or have you experienced any of the following symptoms consistent with COVID-19 within the last ten (10) days: Fever or Chills, Cough, Shortness of Breath or Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, and/or Diarrhea?**

☐ **Within the last ten (10) days, have you had close contact with a person confirmed or suspected to be positive with COVID-19?**

If yes, are you up to date on COVID-19 vaccinations
□ Yes □ No

OR

have had confirmed COVID-19 within the past 90 days (you tested positive using a viral test)?
□ Yes □ No

☐ **Have you tested positive for COVID-19 within the last ten (10) days or are you currently awaiting COVID-19 test results?**

If yes, please indicate:

Date(s) and result(s) of any tests _____

Date of symptom(s) onset _____

Have you been fever-free for 24 hours (without the use of fever-reducing medication
□ Yes □ No

AND

are your symptoms improving?
□ Yes □ No

☐ **Does not meet any of the above criteria.**

_____ _____
Print Patient Name Print Responsible Party Name (if applicable)

_____ _____
Patient or Responsible Party Signature Date