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Patient Screening Form

This screening form should be used twice; once during pre-screening (e.g. over the phone when confirming the appointment), and a second time when the patient presents at the office for their appointment. Answers to these questions must be documented in the patient record.

Patient Name: ___________________________________ Age: _______

1. Have you tested positive for COVID-19 or have been advised by your physician or local public health department to self-isolate?

   ☐Yes ☐No

2. Do you have or recently had (14-21 days) any of the following symptoms:

   ☐Yes ☐No Fever or feeling hot, chills/feverish

   ☐Yes ☐No Shortness of breath or other difficulties breathing

   ☐Yes ☐No Cough or worsening of a chronic cough

   ☐Yes ☐No Flu-like symptoms such as stomach upset, diarrhea, headache, or fatigue

   ☐Yes ☐No Recent alteration or loss of taste or smell

   ☐Yes ☐No Any new, unusual symptoms, e.g., malaise or sudden onset of runny nose

3. Have you been in contact with anyone with confirmed COVID-19 or with any of the above symptoms of possible COVID-19?

   ☐Yes ☐No

4. Do you have heart, lung or kidney disease, diabetes, or any auto-immune disorders?

   ☐Yes ☐No

5. Have you travelled in the past 14 days to any COVID-19 hot spots?

   ☐Yes ☐No

6. Have you been in gatherings of more than 10 people?

   ☐Yes ☐No

7. Have you not been practicing social distance?

   ☐Yes ☐No

"YES" responses to any of these questions would indicate the need for a deeper discussion with the dentist before proceeding with treatment. Whenever possible, patients with one or more risk factors should be rescheduled to a later date.

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