COVID-19 Patient Screening Form

For use guidelines: One form per patient appointment. Ask the patient these questions at the time appointment is made or with an appointment reminder, and again no more than two days before the appointment. Take the patients' temperature and note any signs of fever, coughing, or shortness of breath.

Patient/Parent/Guardian Name:_____ Temperature:_____

Screening Questions	**Call Date:**	**Notes:**
Do you have a fever or above normal temperature?	○ Yes ○ No	
Are you experiencing any shortness of breath or trouble breathing?	○ Yes ○ No	
Do you have a dry cough, runny nose, or sore throat? If so which?	○ Yes ○ No	
Have you had any reduction in your sense of taste or smell?	○ Yes ○ No	
Are you experiencing chills or repeated shaking with chills? If so which?	○ Yes ○ No	
Have you recently had any unexplained muscle pain, headaches, or tingling of extremities? If so which?	○ Yes ○ No	
Even if you don't currently display any of the above symptoms have you experienced and of these symptoms in the past 14 days?	○ Yes ○ No	
Have you been with someone who has tested positive for COVID-19 in the past 14 days?	○ Yes ○ No ○ Unsure	
Have you been tested for COVID-19 (If no skip the next question)	○ Yes ○ No	
-**If yes** what was the result of the testing -**If negative**, proceed to next question -**If still waiting on results**, reschedule appointment until results come in	○ Positive ○ Negative ○ Results pending	
Have you traveled more than 100 miles from your home in the past two months?	○ Yes ○ No	

Patient signature required at appointment:

I agree to notify the staff at Ellen M. Pacleb DDS if within 14 days I become ill or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff member I had contact with tested positive for COVID-19 within 14 days.

Patient/Parent/Guardian Signature:_____

Date:_____