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Pre-Appointment Covid-19 Screening

Screening questions	NO	YES
Do you have a fever or above (>100.4° F)?		
Do you have a trouble breathing or dry cough?		
Do you have a runny nose?		
Do you have a sore throat?		
Do you have a headache?		
Do you have unexplained muscle pain?		
Have you lost sense of smell or taste?		
Are you experiencing chills or repeated shaking with chills?		
In the last 14 days have you experienced any of these symptoms?		
In the last 14 days have you been in contact with someone who has tested positive for COVID-19?		
In the last 7 days have you been tested for COVID-19?		
In the last 14 days have you traveled more than 100 miles from your home ?		
What was the result of your COVID-19 test?	NEG	POS

Patient signature required at appointment:
I agree to notify the dental practice if within 14 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 contact with tested positive for COVID-19 within 14 days.

Signature ____