VISITOR/PATIENT COVID SCREENING FORM

Please complete the following form no more than two days prior DENTAL APPOINTMENT.

I am a: \_\_\_ Visitor \_\_\_\_Patient \_\_\_Caregiver accompanying patient

Today’s Date:

 Patient’s First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR CONTACT INFORMATION

First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Address: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a fever, cough, shortness of breath or difficulty breathing? Yes \_\_ No \_\_

2. In the last 14 days have you travelled more than 100 miles from your home? Yes \_\_ No \_\_

3. Have you had any contact with a confirmed or probable case of COVID-19 or person with acute respiratory illness (fever, cough, shortness of breath) who has travelled more than 100 miles from you’re in the last 14 days? Yes \_\_ No \_\_

4. Do you have two (2) or more of the following symptoms below? Yes \_\_ No \_\_

5. Have you been test ed for Covid-19 in the last 14 days? Yes\_\_ No\_\_

If yes, what is the result of the testing? Negative \_\_\_\_\_ Positive\_\_\_\_\_\_ Unsure \_\_\_ If you are still waiting for results, we will need to reschedule your appointment. Please call us at (415) 479-2302.

• Sore throat • Hoarse Voice • Difficulty swallowing or breathing • Decrease or loss of sense of taste/smell • Chills • Headaches • Unexplained fatigue/malaise or muscle pain • Diarrhea • Abdominal pain • Nausea/vomiting • Dry Cough • Runny nose/sneezing without other known cause • Nasal congestion without other known cause

Patient signature required at appointment

I agree to notify the dental practice if within 2 days I become ill with Coviid-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 2 days

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_