



COVID-19 Screening Form

Patient Name: _____

	Date: _____	Date: _____	Date: _____
Do you or have you had a fever within the past 14-21 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or have you had a dry cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a runny nose or sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you recently lost or had a reduction in your sense of smell or taste?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any flu-like symptoms such as headache, chills, or muscle pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you traveled more than 100 miles from your home in the last 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been tested for COVID-19 in the last 14 days? If "no", skip next question.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Results of COVID-19 test:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unsure	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unsure	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unsure

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: X _____