DESTEFANO
DENTISTRY

PATIENT SCREENING FORM

Patient Name: _____

	Pre-Appointment	In-Office
	Date: _____	Date: _____
Do you/they have a fever, or have you/they felt hot or feverish recently (14-21 days)?	☐ Y ☐ N	☐ Y ☐ N
Are you/they having shortness of breath or other difficulties breathing?	☐ Y ☐ N	☐ Y ☐ N
Do you/they have a cough?	☐ Y ☐ N	☐ Y ☐ N
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐ Y ☐ N	☐ Y ☐ N
Have you/they experienced a recent loss of taste or smell?	☐ Y ☐ N	☐ Y ☐ N
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Y ☐ N	☐ Y ☐ N
Is your/their age over 60?	☐ Y ☐ N	☐ Y ☐ N
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	☐ Y ☐ N	☐ Y ☐ N
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Y ☐ N	☐ Y ☐ N

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

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