

COVID-19 Pre-appointment Check

TO PROTECT ALL OF OUR PATIENTS, STAFF AND DOCTORS WE REQUIRE COMPLETION OF THIS SURVEY - FAILURE TO COMPLETE THIS FORM WILL PRECLUDE YOU FROM SECURING A RESERVED TIME IN OUR SCHEDULE.

Patient Name: _____

	PRE- APPOINTMENT	IN-OFFICE
	Date: _____	Date: _____
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes No	Yes No
Are you/they having shortness of breath or other difficulties breathing?	Yes No	Yes No
Do you/they have a cough?	Yes No	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache, runny nose, sneezing, cough, raspy voice or fatigue?	Yes No	Yes No
Have you/they experienced recent loss of taste or smell?	Yes No	Yes No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	Yes No	Yes No
Is your/their age over 60?	Yes No	Yes No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No	Yes No

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