Patient Screening Form.

Patient Name:

	Yes	No
Do you have fever or have you felt hot or feverish recently (14-21 days) ?		
Are you having shortness or breath or other difficulties breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?		
Have you experienced recent loss of taste or smell?		
Do you have a sore throat?		
Have you been in contact with any confirmed COVID- 19 patients (*Patients who are well but who have asick family member at home with COVID-19 should consider postponing elective treatment.)*		
Have you tested positive for COVID-19 ?		
Have you been tested for COVID-19 and are awaiting results?		
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-inmune disorders?		
Is your age over 60?		
Have you traveled in the past 14 days to any regions affected by COVID-19? (NEW YORK. NEW JERSEY, EUROPE, ASIA, CRUISE)		
Today´s temperature		

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

By signing this document, I acknowledge that the answers I have provided are true and accurate.

Signature **Date**