COVID-19 Patient Screening Form

Patient Name	Before Appointment	In-Office Appointment
Are you over 60 years of age?	YES/NO	YES/NO
Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	YES/NO	YES/NO
Are you experiencing shortness of breath or trouble breathing?	YES/NO	YES/NO
Do you have a temperature of 100.4° F or higher?	YES/NO	YES/NO
Are you experiencing a sore throat?	YES/NO	YES/NO
Are you coughing?	YES/NO	YES/NO
Are you experiencing repeated shaking with chills?	YES/NO	YES/NO
Do you have muscle aches?	YES/NO	YES/NO
Are you experiencing gastrointestinal changes?	YES/NO	YES/NO
Have you noticed a loss of smell or taste?	YES/NO	YES/NO
Have you had contact with a known or suspected COVID-19-positive person?	YES/NO	YES/NO
In the last 14 days, have you traveled to an area that has a high incidence of COVID19?	YES/NO	YES/NO
If yes to the question above, please specify:		

Legal Disclaimer: This form is for sample purposes only. Consult with your attorney and your professional liability carrier to ensure that all of the dental practice's informed consent forms comply with state law. ***(This document should be customized for your office.)***

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