Perry Dental Patient Screening Form

Patient Name: _____

	PRE-APPOINTMENT Date: _____	IN-OFFICE Date:_____
Do you have a fever or have you felt hot or feverish recently (in the last 14-21 days)	(circle one) Yes or No	(circle one) Yes or No
Are you having shortness of breath or other difficulties breathing?	Yes or No	Yes or No
Do you have a cough?	Yes or No	Yes or No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes or No	Yes or No
Have you received recent loss of taste	Yes or No	Yes or No

(over)

Are you 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.*	Yes or No	Yes or No
Are you over the age of 60?	Yes or No	Yes or No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes or No	Yes or No
Have you traveled in the last 14 days to any regions affected by Covid-19?	Yes or No	Yes or No
Have you ever been tested positive for Covid-19?	Yes or No	Yes or No
Do you reside in a senior home, nursing home or group home?	Yes or No	Yes or No

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