Patient Screening

Revised Dec 1st, 2020

Scheduled with _____

Patient of DR._____

Patient Name: _____ Chart# _____ **Patient age:**_____

Screening Questions	Pre-Screen	In-Office
1. **Have you** been in a <u>specific location</u> now identified as a possible exposure site (within the last 14 days)?	YES NO	YES NO
2. Do you have ***any two*** of the following symptoms *that are not related to a known pre-existing condition:* A fever anytime in the last two weeks? Cough? Sore throat? Runny nose? Headache? Loss of taste or smell? Fatigue/exhaustion? Muscle Pain? Diarrhea? *Children: Any purple markings on fingers/toes?* YES NO	YES NO	YES NO
3. Have you been advised by Public Health, a health care provider, or peace officer, that you are currently required to self-isolate?	YES NO	YES NO
4. Have you been in close contact with, any confirmed COVID-19 positive patients, **OR** persons self-isolating because of a determined risk for COVID-19, **OR** persons who have been in a specific location now identified as a possible exposure site (within the last 14 days)?	YES NO	YES NO
5. Have you returned from travel (includes essential workers) within Canada/US from a location known to be affected with COVID-19 **OR** been in close contact with someone who has – within the last 14 days?	YES NO	YES NO
6. a) Are you waiting for a Covid-19 test or Covid-19 test results b) Have you been advised to self-isolate while waiting for results?	YES NO YES NO	YES NO YES NO
7. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder (these conditions put you at higher risk of complications from Covid-19)?	YES NO	YES NO

I verify the information I have provided on this form is truthful and accurate. I understand that it is not possible to maintain strict social distancing during dental office visits. I knowingly and willingly consent to have dental treatment completed during the Covid-19 pandemic.

Signature _____ **Temperature**:_____ Date:_____