Patient Screening Form

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 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? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ 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
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ 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.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

COVID-19 Pandemic Dental Treatment Consent and Acknowledgment of Risk

I, parent/guardian of _____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic upon my child.

I understand the COVID-19 virus has a long intubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits of the virus testing.

Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air which can transmit the COVID-19 virus.

I confirm that my child is not presenting any of the following symptoms of COVID-19 as listed below:

Fever	Shortness of Breath
Loss of Taste or Smell	Dry Cough
Sore Throat	Chills
Runny Nose	Repeated Shaking with Chills
Muscle Pain	Headache _____ (initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC also recommended social distancing of at least 6 feet for a period of 14 days to anyone who has. This is not possible with dentistry. _____ (initial)

I verify that my child nor I have been in contact with a person that has been diagnosed with COVID-19 within the last 14 days. _____ (initial)

I verify that I have not travelled internationally or domestically within the United States by commercial airline, bus or train within the last 14 days. _____(initial)

Child's Name: _____

Parent's/Guardian's Name: _____

Date: _____