Patient Name:_____

	Pre-Appointment:	**In Office:**
	Date:	**Date:**
Do you/they have fever or you/they felt hot 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 confirm COVID-19 positive Pts Patients who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment.	☐YES ☐NO	☐YES ☐NO
Are you/they in contact with anyone that has been tested or waiting on results for COVID-19 recently (14-21 days) ?	☐YES ☐NO	☐YES ☐NO
NP Only- Is your/they age over 65?	☐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