Patient Covid 19 Screening Form

Patient Name:	Cell phone:	Pre Appointment	In Office

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 reschedule their appointment)*	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___
	Initials____	Initials____

Patient Temp _____

Tikson & Eichenlaub
FAMILY DENTAL