Covid-19 Patient Health Screening Form

Patient name _____

	Pre-Appt Date	In-Office Date
Age _____ Temperature taken by _____		_____F
1. Have you been wearing your mask in public and practicing social distancing? (per state and local guidelines)	Yes___No___	Yes___No___
2. Do you have heart disease, high blood pressure, lung disease, kidney disease, diabetes, any auto immune disease, or in treatment for cancer?	Yes___No___	Yes___No___
3. Have you been around anyone who was sick in the last 14 days?	Yes___No___	Yes___No___
4. Have you been in contact with any confirmed COVID 19 patients? If so, we will reschedule any elective treatment.	Yes___No___	Yes___No___
5. Within the last 14 days have you traveled out of your area or to any foreign country? If so, where?	Yes___No___	Yes___No___
6. Do you have a fever or have you felt hot or feverish recently? (past 14 – 21 days) 100* or higher.	Yes___No___	Yes___No___
7. Are you having shortness of breath or other difficulties breathing?	Yes___No___	Yes___No___
8. Do you have a dry cough? Or sneezing more frequently?	Yes___No___	Yes___No___
9. Are you experiencing muscle aches, weakness or more than normal fatigue?	Yes___No___	Yes___No___
10. Do you have any other flu-like symptoms, such as loss of appetite, nausea, headache, chills, sore throat, diarrhea?	Yes___No___	Yes___No___
11. Have you experienced a recent loss of taste and/or smell? Or have a recent unexplained rash?	Yes___No___	Yes___No___

I acknowledge that receiving dental services may involve a possible exposure to COVID-19, and I accept that risk. If I develop a cough, fever or flu like symptoms within 14 days of my appointment, I will get tested for Covid 19 and notify Dr. Hansen if the test is positive.

Patient's signature _____Date_____