Patient Screening Form for COVID-19

Name: ____

Date: ____

	Before Appointment	At Office
	Date: ______________	Date: ______________
Have you tested positive for COVID-19 or are you awaiting results for a COVID-19 test?	▢ Yes ▢ No	▢ Yes ▢ No
Do you have any of the following: ● Fever ● Cough ● Sore throat ● Cold or flu-like symptoms	▢ Yes ▢ No	▢ Yes ▢ No
Are you having shortness of breath or other difficulties breathing?	▢ Yes ▢ No	▢ Yes ▢ No
Have you experienced recent loss of taste or smell?	▢ Yes ▢ No	▢ Yes ▢ No
Even if you do not currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	▢ Yes ▢ No	▢ Yes ▢ No
Are you, or have you in the last 14 days, in contact with any confirmed COVID-19 positive patients?	▢ Yes ▢ No	▢ Yes ▢ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	▢ Yes ▢ No	▢ Yes ▢ No
Have you travelled outside of Canada in the past 14 days, or been in close contact with someone who returned from abroad?	▢ Yes ▢ No	▢ Yes ▢ No
Temperature Check:	________________oC	________________oC

If there is a positive response to any of these, we would recommend discussing with the dentist and team before proceeding with any elective dental treatment.