COVID-19 Patient Screening

Our ultimate goal is your health. To keep you and our team safe, we ask that you fill out the following screening form prior to your visit today.

1. Have you traveled internationally in the last 21 days? Yes No
2. Have you traveled via a domestic flight in the last 21 days? Yes No

   If Yes, where? _____
3. Are you or have you recently experienced a cough? Yes No
4. Are you or have you recently experienced a fever? Yes No
5. Are you or have you recently experienced shortness of breath? Yes No
6. Are you or have you recently experienced any other flu-like symptoms? Yes No

I confirm these answers are accurate. I further understand that there is some risk of contracting viruses, including COVID-19, by having dental work done today.

Patient Name Printed: _____

Patient/Guardian Signature: _____

Date: _____