Patient Screening Form

Patient Name: %NAME%

	PRE-APPOINTMENT	IN-OFFICE
	Date: %DATE%	Date:
Do you have fever or have you felt hot or feverish (14-21 days)?	%val1%	Yes No
Are you having shortness of breath or other difficulties breathing?	%val2%	Yes No
Do you have a cough?	%val3%	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	%val4%	Yes No
Have you experienced recent loss of taste or smell?	%val5%	Yes No
Are you 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 consider postponing elective treatment.*	%val6%	Yes No
Is your age over 60?	%val7%	Yes No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	%val8%	Yes No
Have you traveled out of the state or to any regions affected by COVID-19 in the past 14 days?	%val9%	Yes No

If you experience any COVID-19 symptoms in the next 14 days, please call the office to let us know.

I am aware that there is a risk associated with obtaining treatment at this time %CONSENT%