ELLIOTT BAY DENTAL

COVID-19 Patient Screening Form

Patient Name: _____ Temp: _____

	PRE-APPOINTMENT Date:	IN-OFFICE Date:
Have you/they tested positive for COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ 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
Do you/they have any flu-like symptoms such as gastrointestinal upset, headache, or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced a recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate rescheduling your appointment or a further discussion with the dentist before proceeding with dental treatment.

By my signature below, I certify the information I provided on this form is true and correct to the best of my knowledge. I also acknowledge that there is a risk to spread and/or contract COVID-19 in a healthcare setting.

_____ _____

Patient/Guardian Signature Date