**Patient Screening Form**

**Patient Name:**

**Temperature (office use only):**

**Date:**

**Do you have a fever, or have you felt hot or feverish recently (14-21 days)?** Yes No

**Are you having shortness of breath or other difficulties breathing?** Yes No

**Do you have a cough?** Yes No

**Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue.** Yes No

**Have you experienced a recent loss of taste or smell?** Yes No

**Have you been in contact with any confirmed COVID-19 positive patients?**

Yes No

**(Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.)**

**Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)** Yes No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.