**Patient Name:**

|  |  |  |
| --- | --- | --- |
|  | PRE-APPOINTMENT | IN-OFFICE |
|  | Date: | Date: |
| Do you/they have fever or have you/they felt hot or feverish recently  (14-21 days)? | 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 |
| Any other flu-like symptoms, such as gastrointestinal upset, headache  or fatigue? | Yes No | Yes No |
| Have you/they experienced recent loss of taste or smell? | Yes No | Yes No |
| Are you/they 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.* | Yes No | Yes No |
| Is your/their age over 60? | Yes No | Yes No |
| Do you/they have heart disease, lung disease, kidney disease,  diabetes or any auto-immune disorders? | Yes No | Yes No |
| Have you/they traveled in the past 14 days to any regions affected  by COVID-19? (as relevant to your location) | Yes No | Yes No |

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

* For testing, see the list of [State and Territorial Health Department Websites](about:blank) for your specific area’s information.