**Patient Name:**

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| --- | --- | --- |
|  | 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 for your specific area’s information.