Pediatric Dental Associates

PATIENT SCREENING FORM

Patient Name(s):

Date:

Please answer these questions for yourself and your child/children:

Do you/they have a fever or have you/they felt hot or feverish recently?	YES NO
Are you/they having shortness of breath or other difficulties breathing?	YES NO
Do you/they have a cough?	YES NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES NO
Have you/they experienced recent loss of taste or smell?	YES NO
Are you/they in contact with any confirmed COVID-19 positive patients?	YES NO
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	YES NO

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

To be completed by office staff:

Are temperatures below 100.4 degrees for all persons?	YES NO

Staff Initials:_____