



Stephen D Cochran, DMD | Flavio M Soares, DDS | Jacqueline M Fetner, DMD

**All are Diplomats of the American Board of Pediatric Dentistry*

PATIENT SCREENING

Patient Name(s):

Date:

Patient Sex:

Patient Age:

	PRE-APPOINTMENT		IN-OFFICE	
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes	No	Yes	No
Do 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? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	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.

Signature:

Date:

PATIENT, PARENT OR GUARDIAN SIGNATURE