Apical Endodontics

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COVID-19 Patient Screening Form

Patient/Parent/Guardian Name (s) _____

Please circle the appropriate box for each question:

1)	Do you have a fever or above-normal temperature (>100.4° F)?	Yes	No
2)	Are you experiencing shortness of breath or having trouble breathing?	Yes	No
3)	Do you have a dry cough?	Yes	No
4)	Do you have a runny nose?	Yes	No
5)	Have you recently lost or had a reduction in your sense of smell or taste?	Yes	No
6)	Do you have a sore throat?	Yes	No
7)	Are you experiencing chills or repeated shaking with chills?	Yes	No
8)	Do you have unexplained muscle pain?	Yes	No
9)	Do you have a headache?	Yes	No
10)	Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	Yes	No
11)	Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	Yes	No
12)	Have you been tested for COVID-19 in the last 14 days?	Yes	No
13)	Have you traveled more than 100 miles from your home in the Last 14 days?	Yes	No

I attest that all answers given above are true. I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature_____ Date_____