Patient Screening Form

Temperature: _________

Patient Name:

Verify Insurance Coverage: YES NO (Circle one)

Employer: **Carrier:**

Notes:	**PRE-APPOINTMENT**	**INOFFICE**	**Parent/Other**
	Date:	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes No	Yes No	Yes No
Are you/they having shortness of breath or other difficulties breathing?	Yes No	Yes No	Yes No
Do you/they have a cough?	Yes No	Yes No	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No	Yes No	Yes No
Have you/they experienced recent loss of taste or smell?	Yes No	Yes No	Yes No
Are you/they in contact with any confirmed COVID-19 positive patients? If yes, please explain ________________________________ ____	Yes No	Yes No	Yes No
Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.			
Have you/they traveled in the past 14 days to any regions heavily affected by COVID-19? (as relevant to your location)	Yes No	Yes No	Yes No
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	Yes No	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.

Patient Signature X___________________________ Date: ________

S:Drive, Documents on Server, Patient Screening Form

Kevin M. Rebhan, DDS
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