

Patient Name:

| | 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? <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.