Patient Screening Form

Patient Name

	Pre-Appointment	In-Office
	Date	Date

PATIENT SCREENING

	Pre-Appointment	In-Office
Have you/they been vaccinated for SARS-CoV-2 (COVID-19)?	○ Yes ○ No	○ Yes ○ No
If yes, when was your/their last shot?		
Which vaccination did you/they receive?		
Have you/they recently tested for COVID-19?	○ Yes ○ No	○ Yes ○ No
If yes, please specify test date		
Have you/they tested positive for COVID-19?	○ Yes ○ No	○ Yes ○ No
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? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	○ 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

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful response and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date