elitesmiles
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# Patient Screening Form

**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 | Yes |
| Are you/they having shortness of breath or other difficulties breathing? | Yes | Yes |
| Do you/they have a cough? | Yes | Yes |
| Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? | Yes | Yes |
| Have you/they experienced recent loss of taste or smell? | Yes | Yes |
| 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 | Yes |
| Is your/their age over 60? | Yes | Yes |
| Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? | Yes | Yes |
| Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location) | Yes | Yes |

**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.