Patient Screening Form for COVID-19

Patient Name: _____

	PRE-APPOINTMENT	AT OFFICE
	Date: _____	Date: _____
Have you tested positive for COVID-19 or are you awaiting results for a COVID-19 test?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any of the following: • Cold or flu-like symptoms • Fever • Cough • Sore throat	☐ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Even if you do not currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ Yes ☐ No	☐ Yes ☐ No
Are you, or have you in the last 14 days, in contact with any confirmed COVID-19 positive patients?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Temperature Check:	N/A	_____ °C

If there is a positive response to any of these, we would recommend discussing with the dentist and team before proceeding with any elective dental treatment.

By signing this document, you acknowledge the following:

Initials _____I willingly consent to treatment during a pandemic and und understand social distancing cannot be maintained while delivering treatment.

Initials _____ I understand that if I have a confirmed or suspected case of COVID-19 within the 14 days following my dental visit, I will inform the dental office.

Initials ____ I have not returned from any country outside of Canada in the past 14 days.

Signature of Patient/Guardian _____