



**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 by plane in the last 30 days, traveled out of state in the last 14 days, or have you been exposed to anyone who has tested positive in the last 14 days?	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.**