

Patient Screening Form

Patient Name

PATIENT SCREENING

Have you/they been vaccinated for SARS-CoV-2 (COVID-19)?.....

Have you/they recently received a booster shot for COVID-19?.....

If yes, when was your/their last shot?

Which vaccination did you/they receive?

Have you/they recently tested for COVID-19?.....

If yes, please specify test date

Have you/they tested positive for COVID-19?.....

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?.....

Are you/they having shortness of breath or other difficulties breathing?.....

Do you/they have a cough?.....

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?.....

Have you/they experienced recent loss of taste or smell?.....

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.

Is your/their age over 60?.....

Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?.....

Have you/they traveled in the past 14 days to any regions affected by COVID-19?.....
(as relevant to your location)

Pre-Appointment

Date

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

In-Office

Date

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

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