GREAT SMILES

PEDIATRIC DENTISTRY & ORTHODONTICS

COVID-19 Patient Screening Form

Patient Name: _____ Appointment Date: _____

Email address: _____ Cell Phone: _____

Screening Questions:

Does you, your child or anyone else you have recently been in contact with have any of the following symptoms?

Symptom	Yes	No
Fever (defined as above 100.4 degrees F)?		
Chills?		
Cough?		
Sore Throat?		
Shortness of breath and/or trouble breathing?		
Persistent muscle pain, pressure or tightness in the chest?		
New loss of taste or smell?		

Have you or your child traveled outside of our local area or outside of the US within the past 14 days? ☐ Yes ☐ No

Have you or your child or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease? ☐ Yes ☐ No

If yes, please provide approximate dates of illness:
Symptoms start date _____ through symptoms end date _____

☐ I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's appointment to a later date.

_____ _____
Parent/Guardian Name (if applicable) Relation

_____ _____
Patient/Parent/Guardian Signature Date

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For Office Use - Patient Temp: _____degrees F, Parent/Guardian Temp: _____degrees F