PATIENT HEALTH SCREENING

Patient Name: _____ **Date:**_____

FORM AVAILABLE ON OUR WEBSITE - applepediatricdentistry.com

In an effort to reduce the risk of COVID-19 exposure please answer the following:

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No
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 ☐ No
Is patient age over 60?	☐ Yes ☐ No
If Yes, are you willing to proceed, knowing potential increased risk?	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No
If Yes, are you willing to proceed, knowing potential increased risk?	☐ Yes ☐ No

Positive responses questions may indicate the need for further discussion with dentist prior to proceeding with elective treatment.

It is not possible to prevent 100% against the presence of all disease. We diligently follow all CDC & ADA health recomendations to prevent you [or your child(ren)] and our staff from becoming exposed to, contracting, or spreading COVID-19 while in our office; therefore, if you choose to utilize our services and/or enter our premises you may be exposing yourself to and/orincreasing your risk of contracting or spreading COVID-19. Signature below achknowledges potential risk and indicates willingness to proceed with todays appointment.

Guardian signature *or* (Patient if over 18yrs): _____

Guardian printed: _____

Relationship: _____