SANFORD SMILES
FAMILY DENTISTRY

PATIENT NAME: _____ DATE: _____

In an effort to protect our patients, from illness we are screening all patients and staffs. Please answer the following questions

1. Within the past 14 days, I have been sick with a cold or the flu Y / N
2. Within the past 14 days, I have travelled outside of USA or on the domestic/international flight Y / N
3. Within the past 14 days, I have been around people who have travelled outside of USA Y / N
4. Within the past 14 days, I have been around people who Have been or are sick with colds/flu Y / N
5. I have been tested POSITIVE for COVID-19 Y / N
6. I have been around people who tested POSITIVE for COVID-19 Y / N
7. Within the last 14 days, I have had a fever Y / N
8. Within the last 14 days, I have had nausea/vomiting/diarrhea Y / N
9. Within the last 14 days, I have lost TASTE/SMELL Y / N

PATIENT SIGNATURE: _____