Naper West Dental Associates
Covid-19 Patient Screening Form

Patient Name: _____

Arrival Body Temp. °F *(for dental staff only)*		**PRE-APPOINTMENT**	**IN-OFFICE**
SpO2 %	**Olfaction Test P / F** *(for dental staff only)*	Date:	Date:
Do you have fever or have you felt hot or feverish recently (14-21 days)?		Yes No	Yes No
Are you having shortness of breath or other difficulties breathing?		Yes No	Yes No
Do you 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 experienced recent loss of taste or smell?		Yes No	Yes No
Are you 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	Yes No
Is your age over 60?		Yes No	Yes No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?		Yes No	Yes No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)		Yes No	Yes No

Positive responses to any of these would likely indicate a deeper discussion with Dr. Law before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Patient's Printed Name: _____
Date:_____

Patient's Signature: _____