In office screening protocol for patients and DHCP

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?_____YES / NO

HAVE YOU HAD A FEVER OF 100.4 OR GREATER IN THE LAST 14 DAYS? _____YES / NO

DO YOU HAVE ANY SHORTNESS OF BREATH?_____YES / NO

DO YOU HAVE SNEEZING, SINUS ISSUES, RUNNY NOSE, SOAR THROAT, COUGH

THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? _____YES/ NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? _____YES / NO

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? _____YES / NO

HAVE YOU BEEN IN CONTACT WITH A COVID-19+ PERSON IN THE LAST 14 DAYS?_____YES / NO

You should contact our office if you experience COVID-19 symptoms
within 2 days after the dental appointment.

_____ _____

PATIENT / RESPONSIBLE PARTY DATE