smiles4children
Dentistry for Infants, Children, Young Adults, and Special Needs

Patient and Accompanying Adult Screening Form

Patient Name:

Do you/they have a fever or have you 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 Upset stomach, diarrhea, 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 or COVID-19 symptom patient? *(Per CDC, Patients who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment)*	YES	NO
Do you/they have heart, lung, kidney disease?	YES	NO
Do you/they have diabetes or any auto-immune disease?	YES	NO

Temperature /Pulse Ox for Patient: /

for Accompanying Adult: /

Signed by Guardian: Date: