Drake Dental

Patient Screening Form

Patient Name: _____ Temp: _____

	YES	NO
1. Have you had a confirmed or suspected case of COVID-19?		
2. Have you had contact with or cared for someone with a confirmed or suspected diagnosis of COVID-19 in the last 14 days?		
3. Are you currently experiencing or have you experienced any of the following flu like symptoms within the last week: **Fever, cough, sore throat, runny nose, respiratory illness, difficulty breathing, gastrointestinal upset or any other unusual symptoms (like loss of taste or smell)**?		
4. Do you suspect yourself, any close family member or roommate of having early flu-like symptoms?		
5. Have you done any significant traveling (by plane or mass transit) or attended a mass gathering (conference, concert, etc) within the last 14 days?		
6. Have you been in close contact with someone who has returned from significant traveling (by plane or mass transit) or attended a mass gathering (conference, concert, etc.) in the last 14 days?		
7. Are you over the age of 65? **		
8. Do you have heart disease, lung disease, kidney disease, diabetes or any other auto-immune disorder or health issue that compromises your immune system? **		

** If you answered **YES** to questions #7 or #8, you are at an increased risk of more serious complications if you contract COVID-19. We are still happy to see you and take care of you but want to make sure you are willing to assume this increased risk. Do you feel comfortable keeping your appointment? _____ Yes _____ No