Covid- 19 Patient Screening

Our ultimate goal is your health. To help keep you and our team safe, we ask that you fill out the following screening form prior to your visit today.

1. Have you traveled internationally in the last 21 days? **Yes** **No**
2. Have you traveled via a domestic flight in the last 21 days? **Yes** **No**

   If Yes, where?_____

3. Are you or have you recently experienced a cough? **Yes** **No**
4. Are you or have you recently experienced a fever? **Yes** **No**
5. Are you or have you recently experienced shortness of breath? **Yes** **No**
6. Are you or have you recently experienced any other flu-like symptoms? **Yes** **No**

I confirm these answers are accurate. I further understand that there is some risk contracting viruses, including COVID-19, by having dental work done today.

Name: _____

Print Name: _____

Signature: _____

Date: _____