Pickwick Family Dental Care Patient Name:_____ Date: _____

Patient Screening Questionnaire

Patient Screening Questionnaire

Please answer the following questions based on your pre-appointment state.

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	**Are you/they having shortness of breath or other difficulties breathing?**	**Do you/they have a cough?**	**Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?**
Are you/they 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.

Is your/their age over 70?	**Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?**	**Have you/they traveled in the past 14 days?**

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

State and Territorial Health Department Websites

Signature

The information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes

Signature of Patient, Parent, or Guardian	**Date**