Cedar Point Dental Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you have a fever or have you felt hot or feverish recently (14-21 days)?	Yes No	Yes No
Are you having shortness of breath or other difficulties breathing?	Yes No	Yes No
Do you have a cough?	Yes No	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No	Yes No
Have you experienced a recent loss of taste or smell?	Yes No	Yes No
Are you 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.*	Yes No	Yes No
Have you been recently tested for COVID-19 and are awaiting the results?	Yes No	Yes No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes No	Yes No
Is your age over 60?	Yes No	Yes No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No	Yes No

Please contact our office prior to your appointment if you have a positive response to any of these questions.