Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you have a fever or have you/they 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, runny nose or sore throat?	Yes No	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, muscle ache, headache, chills or fatigue in the last 14 days?	Yes No	Yes No
Have you experienced 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 tested for COVID-19 in the last 14 days?	Yes No	Yes No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No	Yes No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes No	Yes No

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