COVID-19 PATIENT SCREENING FORM

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat

_____ (Initial)

I understand that air travel significantly increases the risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days around anyone who has traveled by air, and this distance is not possible with dentistry.

_____ (Initial)

- I verify that I have not traveled outside the United States during the past 14 days to countries that have been affected by COVID-19. _____ (Initial)
- I verify that I have not traveled within the United States by commercial airline, bus, or train within the past 14 days. _____ (Initial)
- I have not tested positive for the SARS-COV-2 virus (novel coronavirus)? _____ (Initial)

If so, we need two negative test results and a copy of the negative test results before an appointment can be scheduled. _____ (Initial)

Name _____ Date _____