ADA Patient Screening Form

Patient Information			
First Name	Last Name	Date of Birth	Patient Identifier (If known)

Screening Questions	
Do you/they have a fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐ Yes ☐ No
Have you/they experienced a recent loss of taste or smell?	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients?	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	☐ 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

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.
Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.
All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

Parent or Guardian Name (If Applicable)	Relationship to Patient (If Applicable)
Signature of Patient, Parent or Guardian	**Date**