ADA.

Patient Name:

		IN-OFFICE
		Date:
Do you have fever or have you felt hot or feverish recently (14-21 days)?		☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?		☐ Yes ☐ No
Do you have a cough?		☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?		☐ Yes ☐ No
Have you experienced recent loss of taste or smell?		☐ 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
Are you over the age 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.

For testing, see the list of State and Territorial Health Department Websites for your specific area's information.