ADA COVID Patient Screening Form

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Patient First Name: _____

Patient Last Name: _____

DOB: _____

	Yes	no		Yes	no
Do you have a fever or have you felt hot or feverish recently (14-21 days)?	○	○	Do you have a cough?	○	○
Are you having shortness of breath or other difficulties breathing?	○	○	Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? ‘	○	○
Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment	○	○	Are you over the age of 60?	○	○
			Have you experienced recent loss of taste or smell?	○	○
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	○	○	Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	○	○
Are you in contact with any confirmed COVID-19 positive patients?	○	○			

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.

Relationship to the patient: _____

Name: _____

Signature

Sign

Date: _____