COVID-19 Patient Screening Form for the Office of Ronald A. Nakano, DDS

Use one form for each patient appointment. Ask the patient these questions at the time the appointment is made or with the appointment reminder, and again no more than two days before the appointment. Take the patients temperature at the appointment.

Patient Name_____Temperature_____

SCREENING QUESTIONS	Date:_____ Staff Initial:_____	Date:_____ Staff Initial:_____
Do you have a fever or above normal temperature greater than 100.4F?	☐ NO ☐ YES	☐ NO ☐ YES
Are you experiencing shortness of breath or trouble breathing?	☐ NO ☐ YES	☐ NO ☐ YES
Do you have a dry cough?	☐ NO ☐ YES	☐ NO ☐ YES
Do you have a sore throat?	☐ NO ☐ YES	☐ NO ☐ YES
Do you have a runny nose?	☐ NO ☐ YES	☐ NO ☐ YES
Do you have flu-like symptoms? Chills? Repeated shaking? Fatigue?	☐ NO ☐ YES	☐ NO ☐ YES
Do you have unexplained muscle pain?	☐ NO ☐ YES	☐ NO ☐ YES
Do you have gastrointestinal upset?	☐ NO ☐ YES	☐ NO ☐ YES
Have you lost your sense of smell/taste?	☐ NO ☐ YES	☐ NO ☐ YES
Even if you don't currently have any of the above symptoms, have you experienced them within the last 14 days?	☐ NO ☐ YES	☐ NO ☐ YES
Are you in contact with anyone who tested positive for COVID-19?	☐ NO ☐ YES	☐ NO ☐ YES
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	☐ NO ☐ YES	☐ NO ☐ YES
Have you traveled in the past 14 days?	☐ NO ☐ YES	☐ NO ☐ YES

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature_____ Date_____