# Advanced Family Dentistry

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## COVID-19 PATIENT SCREENING FORM

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**In order to safeguard our dental office and the rest of our community, we ask that you arrive at the office wearing a face mask. You will not be allowed entry without a face mask. If we have an adequate patient protective equipment (PPE) supply, we will provide you with a new face mask before you leave our office.**

**If you are experiencing any symptoms related to COVID-19, please call us immediately; we ask that you do not come to our office at this time.**

**Symptoms are tempature over 100.4, cough, shortness of breath, or difficulty breathing**

**Or any two of the following: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell**

**THIS LIST IS NOT ALL INCLUSIVE.**

**Please consult your medical provider if you have any other severe symptoms that concern you. If you develop any of the following symptoms (warning signs) for COVID-19, seek emergency medical attention immediately:**

**Trouble breathing, Persistent pain or pressure in the chest, New confusion or inability to arouse, Bluish lips or face**

****PLEASE CALL US TO RESCHEDULE IF YOU HAVE ANY OF THESE SYMPTOMS****

## PATIENT QUESTIONNAIRE

**1. Have you traveled anywhere in the last 14 days? *** ◯ Yes ◯ No

**2. In the last 14 days, have you been in contact with anyone who was/is sick? *** ◯ Yes ◯ No

**3. In the last 14 days, have you attended any gathering of 5 or more individuals? *** ◯ Yes ◯ No

**4. Have you had any of the following symptoms within the last two weeks: fever, fatigue, dry cough, altered taste, altered smell, trouble breathing, productive cough (mucous in cough), or muscle pain? ***
◯ Yes ◯ No

**5. Have you previously tested positive for SARS-COV-2 virus (COVID-19/Coronavirus)? *** ◯ Yes ◯ No

**6. Are you over the age of 65 and/or have preexisting health conditions related to the following: diabetes, chronic lung disease or asthma, serious heart condition, immunocompromised, or chronic kidney or liver disease? ***
◯ Yes ◯ No

☐ * **By checking this box, you acknowledge that the answers you provided are true and accurate to the best of your knowledge. I am aware that if I answered YES to any of the above questions I am to call 973-263-7300 immediately to reschedule my dental appointment.**

**Response Date:** _____