ABC123 Pediatric Dentistry Patient Screening Form

Spoke To:	Date:	EE Initial:
Patient (1) Name:		
Has the patient or anyone in the household had or currently have any of the following in the last 21 days:		
Fever		€Yes € No
Shortness of breath		€Yes € No
Cough		€Yes € No
Flu-like symptoms		€Yes € No
GI upset		€Yes € No
Headache		€Yes € No
Fatigue		€Yes € No
Experienced the loss of taste or smell		€Yes € No
Has the patient or anyone in the household been in contact with anyone confirmed positive for COVID-19?		€Yes € No
Does the patient have any significant condition such as heart disease, lung disease, kidney disease, diabetes, or any autoimmune disorders?		€Yes € No
Can the patient swish and spit?		€Yes € No
Patient (2) Name:		
Has the patient or anyone in the household had or currently have any of the following in the last 21 days:		
Fever		€Yes € No
Shortness of breath		€Yes € No
Cough		€Yes € No
Flu-like symptoms		€Yes € No
GI upset		€Yes € No
Headache		€Yes € No
Fatigue		€Yes € No
Experienced the loss of taste or smell		€Yes € No
Has the patient or anyone in the household been in contact with anyone confirmed positive for COVID-19?		€Yes € No
Does the patient have any significant condition such as heart disease, lung disease, kidney disease, diabetes, or any autoimmune disorders?		€Yes € No
Can the patient swish and spit?		€Yes € No
DAY OF APPOINTMENT ONLY		**OTHER TEMP (Name/Temp)**
Parent/Guardian Temp:	Patient (1) Temp:	Patient (2) Temp: