PRE-APPOINTMENT IN-OFFICE QUESTIONNAIRE (OFFICE USE ONLY)

Patient Name:

Date of Birth:

Date:

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS

WITHIN the last 14 days….

Yes No 1)Do you/they have had any fever recently?

Yes No 2)Do you/they have had shortness of breath or other difficulties breathing?

Yes No 3)Do you/they have a cough recently?

Yes No 4) Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

Yes No 5) Have you/they experienced loss of taste or smell?

Yes No 6) Have you/they came in contact with any confirmed COVID-19 positive

Yes No 7) Have you/they traveled by plane or cruise ships

Any positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

Thank you

Signature: