Patient Screening Form

ADA®

Patient Name:

	IN-OFFICE
Temp:	**Date:**
Do you/they have fever or have you/they felt hot or feverish recently (14 days)?	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No
Are you vaccinated?	☐ Yes ☐ No
Has it been 14 days since your final vaccination?	☐ Yes ☐ No
Have you/they traveled in the past 10 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No