Creating Healthy Smiles
Dr. Fred Alger
PERIODONTICS & DENTAL IMPLANTS
Practice Limited to Periodontics and Dental Implants

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PATIENT SCREENING FORM

Patient's Full Name _____

	PRE-APPOINTMENT	IN-OFFICE
	DATE:	DATE:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ YES ☐ NO	☐ YES ☐ NO
Are you/they having shortness of breath or other difficulties breathing?	☐ YES ☐ NO	☐ YES ☐ NO
Do you/they have a cough?	☐ YES ☐ NO	☐ YES ☐ NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ YES ☐ NO	☐ YES ☐ NO
Have you/they experienced recent loss of taste or smell?	☐ YES ☐ NO	☐ YES ☐ NO
Are you/they in contact with any confirmed COVID-19 postitive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ YES ☐ NO	☐ YES ☐ NO
Is your/their age over 60?	☐ YES ☐ NO	☐ YES ☐ NO
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immue disorders?	☐ YES ☐ NO	☐ YES ☐ NO
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevent to your location)	☐ YES ☐ NO	☐ YES ☐ NO

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

Signature _____ **Date** _____