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Covid-19 Patient Screening

Patient Name: ______________ ______________ ____ ______________
Last First MI Preferred Name

Our community has been through a lot in the past few months, and all of us are looking forward to resuming our normal routines. While many things have changed, one thing has remained the same here at Dr. Wong's: our commitment to your safety.

Please take a moment to let us know about your overall health so we may serve you more effectively and in a way that watches out for your overall health and well-being and the saftey and well-being of our staff.

Temp ______________

Have you received a COVID-19 vaccine? ◯ Yes ◯ No

Date of Vaccination ______________

Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days? ◯ Yes ◯ No

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you had a fever or above-normal temperature (>100.4 F)?
- ☐ Are you experiencing shortness of breath or having trouble breathing?
- ☐ Do you have a dry cough?
- ☐ Do you havea runny nose?
- ☐ Have you recently lost or had a reduction in your sense of smell or taste?
- ☐ Do you have a sore throat?
- ☐ Are you experiencing chills or repeated shaking with chills?
- ☐ Do you have unexplained muscle pain?
- ☐ Do you have a headache?
- ☐ Even if you dont currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?

Have you been tested for COVID-19 in the last 14 days? ◯ Yes ◯ No

If yes, what is the results of the testing?

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Have you traveled more than 100 miles from your home in the last 14 days? ◯ Yes ◯ No

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☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

Signature of patient, parent, or guardian:

Signature ______________ **Date** ______________

Relationship to Patient:

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