Chen Family Dentistry of Rochester

Patient Screening Form

Patient Name:

	Pre-appointment	In-office
	Date:	Date:
Do you have fever or have you felt hot or feverish recently (14-21 days)?	☐ YES ☐ NO	☐ YES ☐ NO
Are you having shortness or breath or other difficulties breathing?	☐ YES ☐ NO	☐ YES ☐ NO
Do you 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 experienced loss of taste or smell?	☐ YES ☐ NO	☐ YES ☐ NO
Are you in contact with any confirmed COVID-19 positive patients?	☐ YES ☐ NO	☐ YES ☐ NO
Have you traveled in the past 14 days to any regions affected by COVID-19?	☐ YES ☐ NO	☐ YES ☐ NO
Although exposure is unlikely, do you accept the risk and consent to treatment?	☐ YES ☐ NO	☐ YES ☐ NO