BACK TO PRACTICE

PATIENT CARE

California Dental Association
1201 K Street, Sacramento, CA 95814
800.232.7645 | cda.org

Covid-19 Patient Screening Form

Instructions for use: Use one form for each patient appointment. Ask the patient these questions at the time appointment is made or with appointment reminder, and again no more than two days before the appointment. Take the patient's temperature and note any signs of fever, coughing, or shortness of breath.

Patient/Parent/Guardian Names: ____

Screening questions	**Date: / /**	**Date: / /**	**Date: / /**	**Date: / /**
Do you have a fever or above-normal temperature (>100.4° F)? *Take temperature at appointment.*	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Are you experiencing shortness of breath or having trouble breathing?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Do you have a dry cough, runny nose, sore throat, muscle pain, headache?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Have you recently lost or had a reduction in your sense of smell or taste?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Are you experiencing chills or repeated shaking with chills?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Have you experienced any other symptoms associated with COIVD-19 such as a rash, diarrhea or conjunctivitis (pink eye)?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Have you traveled more than 100 miles from your home in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Have you been tested for COVID-19 in the last 14 days? *If "yes," what were your results:*	☐ No ☐ Yes __________	☐ No ☐ Yes __________	☐ No ☐ Yes __________	☐ No ☐ Yes __________
Have you been tested for the antibody? *If "yes," what were your results:*	☐ No ☐ Yes __________	☐ No ☐ Yes __________	☐ No ☐ Yes __________	☐ No ☐ Yes __________

Patient signature required at appointment:

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature ____