Form: ADA COVID Patient Screening Form

Patient Information

FIRST Name

LAST Name

MI

Do you have a fever or have you felt hot or feverish recently (14-21 days)?	YES	NO
Are you having shortness of breath or other difficulties breathing?	YES	NO
Do you have a cough?	YES	NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES	NO
Are you 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
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	YES	NO

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

For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

☐ I consent to use Electronic Records and Signatures (Read Electronic Record and Signature Disclosure)

Relationship to patient

Make a selection

Name

Type Name

Exit without finishing

SIGN

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