Andrew Firtel DDS Inc Patient name and date:_____

Covid 19 Patient Screening Form

1.	Do you have a fever or have you felt hot or feverish recently (14-21 days)?	yes	no
2.	Are you having shortness of breath or other difficulties breathing?	yes	no
3.	Do you have a cough?	yes	no
4.	Any other flu-like symptoms such as gastrointestinal upset, headache, or fatigue?	yes	no
5.	Have you experienced recent loss of taste or smell?	yes	no
6.	Are you in contact with any confirmed COVID-19 positive patients?	yes	no
7.	Is your age over 60?	yes	no
8.	Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	yes	no
9.	Have you traveled in the past 14 days to any regions affected by COVID-19 (as relevant to your location?)	yes	no

Should I become symptomatic with any symptoms of COVID-19 or should I test positive for COVID-19 within the next 14 days after today's appointment, I will inform the dental office immediately.

Patient name and date: _____