# ADA Patient Screening Form

| Patient Information | | | |
|---|---|---|---|
| First Name | Last Name | Date of Birth | Patient Identifier (If known) |
| | | | |

| Screening Questions | |
|---|---|
| Do you/they have a fever or have you/they felt hot or feverish recently (14-21 days)? | ☐ Yes ☐ No |
| Are you/they having shortness of breath or other difficulties breathing? | ☐ Yes ☐ No |
| Do you/they have a cough? | ☐ Yes ☐ No |
| Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue? | ☐ Yes ☐ No |
| Have you/they experienced a recent loss of taste or smell? | ☐ Yes ☐ No |
| Are you/they in contact with any confirmed COVID-19 positive patients? | ☐ Yes ☐ No |
| Is your/their age over 60? | ☐ Yes ☐ No |
| Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders? | ☐ Yes ☐ No |
| Have you/they 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.
Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.
All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

| Parent or Guardian Name (If Applicable) | Relationship to Patient (If Applicable) |
|---|---|
| | |
| **Signature of Patient, Parent or Guardian** | **Date** |
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