COVID-19 PRE-SCREENING QUESTIONNAIRE

Our records indicate that you have an upcoming appointment with our office. Due to COVID-19 global pandemic, please take time to complete this form prior your arrival and return it to us via email at info@professionalfamilydental.com

We will not be able to accommodate your appointment without having received this form before you arrive for your appointment.

In order to safeguard our dental office and the rest of our community, we ask that you arrive at the office wearing a face mask. You will not be allowed entry without a face mask.

If you are experiencing any symptoms related to COVID-19, we ask that you do not come to our office at this time. If you have been exposed to a communicable disease, you may spread the disease to the dentist, office staff, or other patients in the practice.

Prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

1. Have you had any of the following symptoms within the last 14 days:

   - Cough, shortness of breath, or difficulty breathing Y/N
   - Runny nose Y/N
   - Fever (defined as above 99.6 degrees) Y/N
   - Persistent pain, pressure, or tightness in the chest Y/N
   - Chills, Repeated shaking with chills Y/N
   - Headache Y/N
   - Sore Throat Y/N
   - Recent loss or reduction in your sense of smell or taste Y/N
   - Unexplained muscle pain Y/N
   - Nausea, vomiting or diarrhea Y/N

2. Have you been in contact with anyone who has tested positive for COVID-19 or had any of the symptoms indicated in above question?
3. Have you traveled more than 100 miles from your home in the last 14 days?
4. Have you attended any large group functions?
5. Have you received any COVID-19 vaccination? Date received ______________
6. Have you been tested for COVID-19? If so, did you test positive and when was the test taken?

I understand that if the answer to any of these questions is yes, I may be asked to reschedule my dental appointment to a later date.

____

Patient Name Date

____

Parent/Guardian Name Date

____

Signature of Patient or Legal Guardian Date

____

Relationship to patient

____

Witness Date

If you are unable to print this form and email it, please copy and paste the questionnaire into a composed email and send it back with your answers to info@professionalfamilydental.com

We thank you for your cooperation and will contact you if we need further information.

Thank you,

Professional Family Dental Team