CARMEL VALLEY FAMILY DENTAL

Covid-19 PAtient Screening Form

Do you currently have a fever or above normal temperature (100.4f)?	Staff initial: _____ ❑ Y ❑ N
Are you experiencing shortness of breath or having trouble breathing?	Staff initial: _____ ❑ Y ❑ N
Do you have a dry cough, runny nose, or sore throat?	Staff initial: _____ ❑ Y ❑ N
Have you recently lost or had a reduction in your sense of taste or smell?	Staff initial: _____ ❑ Y ❑ N
Are you experiencing any of the following; Chills, shaking, muscle pain, or headache? If yes, please explain.	Staff initial: _____ ❑ Y ❑ N
Have you experienced any of the above symptoms in the last 14 days?	Staff initial: _____ ❑ Y ❑ N
Have you been in contact with anyone who tested positive for COVID-19 in the last 14 days? Traveled in the last 14 days? Y / N	Staff initial: _____ ❑ Y ❑ N
Have you been tested for COVID-19 in the last 14 days? If yes, please circle results in the next column.	Staff initial: _____ ❑ Y Results: Negative / Positive ❑ N

❑ I agree to notify the dental practice within 14 days if 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.

Patient signature Date