BACK TO PRACTICE

PATIENT CARE

DUBUQUE DENTAL ASSOCIATES
1890 John F Kennedy Rd
Dubuque, IA 52002
(563) 556-4234

Covid-19 Patient Screening Form

Patient/Parent/Guardian Names: _____

Screening Questions	Prescreen Date:	Appointment Date:	Notes
Do you have a fever or above-normal temperature (>100.4° F)?	☐ No ☐ Yes	☐ No ☐ Yes	**TEMP:** Staff Initials _____ If patient answers "yes" to either question on shortness of breath or coughing, or answers "yes" to any combination of two other symptoms and the patient does not need emergency care,consider not scheduling or seeing the patient until the symptoms resolve or until the patient can provide proof they are not infectious for COVID-19.
Are you experiencing shortness of breath or having trouble breathing?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a dry cough?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a sore throat?	☐ No ☐ Yes	☐ No ☐ Yes	
Are you experiencing chills or repeated shaking with chills?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have unexplained muscle pain?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a headache?	☐ No ☐ Yes	☐ No ☐ Yes	
Even if you don't currently have any of the above symptoms, have you experienced any symptoms in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	If "yes" and patient does not need emergency care, do not see patient unless it has been more than 7 days since the symptoms first appeared and 3 days of no fever without the use of fever-reducing medication.
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you traveled more than 100 miles from your home in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	Determine if patient followed physical distancing precautions and wore a mask while in public.

Patient signature required at appointment:

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

Signature _____ Date _____