DECISIONONE
DENTAL PARTNERS

# COVID-19 Patient Screening & Consent Form

Patient Name________________________________________________________

1) Has the patient (or someone they live with) returned from travel past 14 days? Yes No

2) Is the patient currently experiencing any of the following flu-like symptoms: Yes No

If yes, which:

________ Fever
________ Chills
________ Muscle aches
________ Runny nose
________ Abdominal pain and/or diarrhea
________ Loss of sense of taste or smell
________ Sore Throat
________ Shortness of breath
________ Nausea/Vomiting
________ Headache
________ Cough

3) Have you been in close contact with someone who has been ill with cough and/or fever within the past 14 days? Yes No

4) Do you have any of the following COVID-19 health risk factors:

________ Over 65
________ Lung condition
________ Immune compromised (HIV, cancer, other)
________ Heart condition
________ High Blood Pressure
________ Diabetes
________ Pregnant

5) Current patient temperature ________________________________________

**I have interviewed the patient and confirm that they are approved to receive dental treatment.**

________________________________
Employee Signature

________________________________
Employee Name

________________________________
Date

**I certify that all information provided is true and correct, and I consent to receive treatment in the COVID environment.**

________________________________
Patient Signature

________________________________
Patient Name

________________________________
Date

Updated May 10th, 2020