PERIODONTICS IMPLANTS

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Patient Screening Form ADA

Patient Name: _____ Temp: _____ Date: _____

	YES	NO
Do you have a fever, or have you felt hot or feverish in the last 2 weeks?	_____	_____
Are you having shortness of breath or other difficulties breathing?	_____	_____
Do you have a cough?	_____	_____
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	_____	_____
Have you experienced recent loss of taste or smell?	_____	_____
Are you in contact with any confirmed COVID-19 Positive patients? *Patients who are well but who have a sick family member at home With COVID-19 should consider postponing elective treatment.*	_____	_____
Do you have heart disease, lung disease, kidney disease, diabetes Or any Auto-immune disorders?	_____	_____
Have you traveled internationally in the past 14 days to any regions heavily affected by COVID-19? (as relevant to your location)	_____	_____

Positive responses to any of these would likely indicate a deeper discussion with the Dentist before proceeding with elective dental treatment.

Signature:_____ Date: _____