ROCHELLE DENTAL

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Rochelle Dental Covid-19 Screening Questionnaire

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the **COVID-19** pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the Covid-19 virus , **we cannot make any guarantees.**

Our staff is symptom-free and, to the best of their knowledge, has not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

Patient Name:_____ **Age**_____**yrs.** **Date:**_____

Are you currently awaiting the results of a Covid-19 test ? Yes____ No____

Do you have a fever or felt feverish recently ? Yes____ No____

Do you have a dry cough ? Yes____ No ____

Do you have shortness of breath or difficulty breathing ? Yes____ No____

Do you have chills or repeated shaking with chills ? Yes____ No____

Do you have any recent onset of headache or sore throat ? Yes____ No____

Do you have any other flu-like symptoms ? Yes____ No____

(ex. sneezing, watery eyes, sinus pain/pressure)

Do you have any recent loss of taste or smell ? Yes____ No____

Have you recently experienced any GI upset or diarrhea ? Yes____ No____

Do you have :

Heart disease Yes____ No____

Lung disease Yes____ No____

Kidney disease Yes____ No____

Diabetes Yes____ No___

Autoimmune disorders Yes____ No____

Signature_____

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