PATIENT SCREENING FORM ONLINE
Harry Randel, DMD PC

NAME: ___________________ **DOB:** ___________________ **Date**: ___________________

Question	Answer
Do you/they have a fever or have your/they felt hot or feverish recently (14-21 days)?	Yes No
Are you/they having shortness of breath or other difficulties breathing?	Yes No
Do you/they have a cough?	Yes No
Have you/they had any other flu-like symptoms, such as gastrointestinal upset, chills, fatigue, sore throat, shortness of breath, chest pain, headaches, muscle aches/pain, or conjunctivitis?	Yes No
In the last month have you/they had any of the above flu like symptoms?	Yes No
Have you/they experienced recent loss of taste or smell?	Yes No
Have you/they come into contact with any confirmed, potential, or quarantined COVID-19 positive patients within the last month?	Yes No
If you tested positive for COVID-19, have you since received a positive test (if you've never tested positive, select no)?	Yes No
Are you/they a health-care worker?	Yes No
Do you/they have any pre-existing health conditions such as: heart disease, kidney disease, liver disease, diabetes, auto-immune disorders, chronic lung disease, asthma, or are immunocompromised?	Yes No
Have you/they traveled in the past 14 days to any regions affected by COVID-19?	Yes No
Please understand we have taken all of the safety precautions possible but the risk of contracting the Covid virus is always a possibility.	I understand
Are all of your answers are truthful to the best of your knowledge? Signature: ________________________________	Yes No

If you answered yes to any questions, Please explain below:

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