Patient COVID Screening Form

This disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

Patient Name: ________________________

Do you have a fever above normal temperature? YES NO

Have you experienced shortness of breath or had trouble breathing? YES NO

Do you have a dry cough? YES NO

Do you have a runny nose? YES NO

Have you recently lost or had a reduction in your sense of smell? YES NO

Do you have a sore throat? YES NO

Have you tested positive for COVID-19? YES NO

Have you traveled outside the United States by air or cruise ship in the past 14 days? YES NO

Have you traveled with in the United States by air, bus or train within the past 14 days? YES NO

I fully understand and acknowledge the above information, risks and cautions regarding a compromise immune system and have disclosed to my provider any conditions in my health history which may result in compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true.

Patient Signature _________________________________

Email form to: info@elkriverfamilydentistry.com of fax to: 763-269-8692