Patient Screening Form

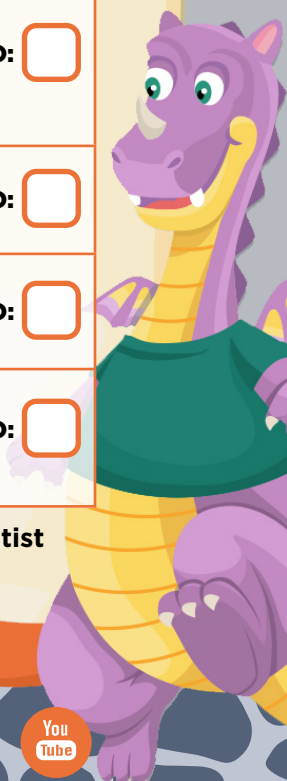
Hines Little Smiles Pediatric Dentistry

patient's name:

parent's name:

	PRE-APPOINTMENT	IN-OFFICE
	DATE:	DATE:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	YES: ☐ NO: ☐	YES: ☐ NO: ☐
Are you/they having shortness of breath or other difficulties breathing?	YES: ☐ NO: ☐	YES: ☐ NO: ☐
Do you/they have a cough?	YES: ☐ NO: ☐	YES: ☐ NO: ☐
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES: ☐ NO: ☐	YES: ☐ NO: ☐
Have you/they experienced recent loss of taste or smell?	YES: ☐ NO: ☐	YES: ☐ NO: ☐
Are you/they 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.*	YES: ☐ NO: ☐	YES: ☐ NO: ☐
Is your/their age over 60?	YES: ☐ NO: ☐	YES: ☐ NO: ☐
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	YES: ☐ NO: ☐	YES: ☐ NO: ☐
Have you/they traveled in the past 14 days to any regions affected by COVID-19? *(as relevant to your location)*	YES: ☐ NO: ☐	YES: ☐ NO: ☐

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



Keeping Little Smiles Happy!