ADA COVID Patient Screening Form

Client Name: ____________________ Date: ___________________

Do you have a fever, or have you felt hot or feverish recently (14-21 days)? ☐ Yes ☐ No

Are you having shortness of breath or difficulties breathing? ☐ Yes ☐ No

Do you have a cough? ☐ Yes ☐ No

Any Flu-Like symptoms, such as gastrointestinal upset, headache, or fatigue? ☐ Yes ☐ No

Have you experienced recent loss of taste or smell? ☐ Yes ☐ No

Are you in contact with any confirmed COVID-19 positive patients? ☐ Yes ☐ No

Do you have heart disease, Lung disease, Kidney disease, diabetes, or any other auto-immune disorder? ☐ Yes ☐ No

Have you traveled in the past 14 days to any regions affected by COVID-19? ☐ Yes ☐ No

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

Temp _____________

Signature

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