# Patient Screening Form

Please complete and return a copy of this form to the dental office at least 48 hours in advance of your scheduled appointment.

Patient Name: _____ Date of Birth: _____

**Address**

Street: _____ Apt#: _____ City: _____

State: _____ Zip:_____

| | Yes | No |
|---|---|---|
| 1. Do you have a fever or have felt hot or feverish anytime in the last two weeks? | ◯ | ◯ |
| 2. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip? | ◯ | ◯ |
| 3. Have you experienced a recent loss of smell or taste? | ◯ | ◯ |
| 4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19? | ◯ | ◯ |
| 5. Have you returned from travel outside of Canada in the last 14 days? | ◯ | ◯ |
| 6. Have you returned from travel within Canada from a location known affected with COVID-19? | ◯ | ◯ |
| 8. Are you over the age of 70? | ◯ | ◯ |
| 9. Do you have any of the following: Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder | ◯ | ◯ |

Please note that no data transmission over the internet can be guaranteed to be 100% secure. As a result, we cannot guarantee the security of any information you transmit to us over the internet, and you do so at your own risk If you would prefer to contact us by telephone to complete this screening questionnaire, please call:

Office Contact Information:

Example: 360 Dental I 123 Street, Vancouver, BC, V5N 1G9 I 604-123-4567 I info@360dental.ca