Patient Screening Form

Patient Name: **Parent/guardian Name (if applicable):**

	Patient	Parent/Guardian (if applicable)
	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 will be rescheduled.*	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 orthodontist before proceeding with treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.