COVID-19 Screening Form

BACKHUS
FAMILY DENTISTRY

Temperature:	Date:
	Please circle
Have you had a fever within the last 14-21 days?	Yes No
Are you having shortness of breath or difficulty breathing?	Yes No
Do you have a cough?	Yes No
Have you experienced a recent loss of taste or smell?	Yes No
Have you been in contact with any confirmed COVID-19 positive patients?	Yes No

Patient Name:

Signature:_____ Date:_____