Platteville Dental

PATIENT SCREENING FORM

EVERY PATIENT REQUIRED TO ANSWER PRIOR TO DENTAL TREATMENT

Do you have a fever or have you felt feverish recently (past 2-3 weeks)?	□Yes □No
Are you having shortness of breath, difficulties breathing, or a cough?	□Yes □No
Any other flu-like symptoms (gastrointestinal upset, headache or fatigue)?	□Yes □No
Have you experienced any recent loss of taste or smell?	□Yes □No
Are you in contact with any confirmed COVID-19 positive patients?	□Yes □No
Have you traveled to any regions affected by COVID-19 in the last 2 weeks?	□Yes □No
Are you over 60?*	□Yes □No
Do you have heart, lung or kidney disease? Or diabetes or any auto-immune disorders?	□Yes □No

***If you are over 60 you are in a higher risk group for COVID-19 complications.**

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