SCHNEIDER FAMILY DENTISTRY SINCE 1940

Covid-19 Patient Screening Questionnaire

Patient Name:_____ Date:_____

Do you have a fever?	YES	NO
Do you have or have you had flu-like symptoms (headache, body aches, chills, cough, fever) in the past 14 days?	YES	NO
Have you experienced a recent onset of respiratory problems, such as a cough or difficulty in breathing within the past 14 days?	YES	NO
Have you come into contact with a patient with a suspected or confirmed Covid-19 infection within the past 14 days?	YES	NO
Have you been on a cruise ship or other close-quarters situation in the past 14 days?	YES	NO
Have you been asked to self-quarantine by any healthcare provider within the past 14 days?	YES	NO
We do our best to limit the spread of all infections, but we cannot guarantee that you will not be exposed to an infectious disease in our office. **Do you want to reschedule your appointment to a future date?**	YES	NO

If you reply YES to any of these questions, we will reschedule your dental procedure to date more than two weeks in the future. It is best for you to self-quarantine at home and report any fever or flu-like symptoms to your healthcare provider.

If you have a fever or flu-like symptoms, you should be quarantined and contact your healthcare provider, hospital, or health department for a COVID-19 test and treatment.

I acknowledge and accept the risk of potential exposure to infectious diseases associated with receiving dental treatment. I understand that Schneider Family Dentistry does its best to limit the spread of all infections, but cannot guarantee that I will not be exposed to an infectious disease in the office.

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Signature of patient or legal guardian