Silberberg Dental Corporation

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Patient Screening Form

Please complete the following form.

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Do you have fever or have you felt hot or feverish recently (14-21 days)? * ☐ Yes ☐ No

Are you having shortness of breath or other difficulties breathing? * ☐ Yes ☐ No

Do you have a cough? * ☐ Yes ☐ No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? ☐ Yes ☐ No

Have you experienced recent loss of taste or smell? * ☐ Yes ☐ No

Are you in contact with any confirmed COVID-19 positive patients? ☐ Yes ☐ No

Are you over 60 years old? * ☐ Yes ☐ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? * ☐ Yes ☐ No

Have you traveled in the past 14 days to any regions affected by COVID-19? * ☐ Yes ☐ No

Patients who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment.

Signature _____ **Date** _____

NOTE:

_____

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_____

Response Date: _____