Covid-19 Screening Questionnaire

Patient Name:____ **Date:**____________________

For the safety of our patients and our staff, we do not treat anyone who is sick, awaiting test results, or quarantining. We are happy to reschedule you to a future date.

What is the patient's temperature when taken today? _________________________

Have you been fully vaccinated against COVID-19?	YES	NO
Have you received a positive COVID-19 test in the past 10 days?	YES	NO
Have you or a household member been directed to quarantine by any healthcare provider within the past 10 days?	YES	NO
Do you have or have you had in the past 14 days any of the following:		
a new or worsening cough, shortness of breath, chest tightness, sore throat, headache, body aches, chills, cough, fever, fatigue, stomachache, diarrhea, or loss of taste or smell?	YES	NO
In the past 10 days, have you or a household member come into close contact (within 6 feet for at least 15 minutes) with a person with a suspected or confirmed COVID-19 infection?	YES	NO
Are you or a household member awaiting COVID-19 test results?	YES	NO

We require documentation of negative PCR test (a rapid test is not sufficient) and a doctor's note for all who are quarantining or have had a positive COVID-19 test within the past 10 days.

NOTE: If you develop COVID symptoms within two weeks (14 days) of being in our office, immediately notify us so we can take proper precautions for our staff and our patients.

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 while in the office.

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Signature of patient or legal guardian