Pediatric Dentistry & Orthodontics of Chattanooga

PDOC

Patient Screening Form

Patient name:_____ Appointment date:_____

Do you, your child or others accompanying you to today's appointment have:

A Fever (temperature above 100.4	**YES____ NO____**
degrees)	**YES____ NO____**
Cough	**YES____ NO____**
Shortness of breath and/or trouble breathing	**YES____ NO____**
Persistent pain, pressure or tightness in chest	**YES____ NO____**
Any other flu-like symptoms	**YES____ NO____**
Experienced recent loss of taste or smell	**YES____ NO____**
Contact with any confirmed COVID-19 positive patients	**YES____ NO____**

Recent travel (within 14 days) to any regions affected by COVID-19

I understand that if the answer to any of these questions is yes, I may be asked to re-schedule today's appointment.

_____ _____ Office use only: Temp_____

Patient/Responsible Party Signature Date Assistant_____