

Jeffrey L. Ash

ENDODONTICS

Patient Name:

	PRE-APPOINTMENT	IN OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you/they had shortness of breath or other difficulties breathing in the last 21 days?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you/they have a cough?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you/they experienced recent loss of taste or smell?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you/they noticed any recent change in appearance in digits (toes/fingers)?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Is your/their age over 60?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you/they experienced a runny nose in the past 21 day?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you/they experienced difficulty swallowing and/or a sore throat?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you (or anyone in your household)/they (or anyone in their household) traveled in the past 14 days? (as relevant to your location)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you/they noticed any other new symptoms not mentioned above?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you/they ever tested positive for COVID-19?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you/they reside in a nursing home, senior living center, or other type of group home?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.