Rocky Point Family Dentistry

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Covid 19: Screening Checklist

Patient Name: _____ DOB _____

Do you or have you been diagnosed with Covid 19? _____ If so, what date were you diagnosed? _____ How long were you quarantined? _____ Do you have a confirmed negative lab result? _____

Have you had contact with anyone diagnosed with Covid 19 in the past month? _____

Do you have any of the following respiratory symptoms:

- ☐ Cough
- ☐ Shortness of breath
- ☐ Fever
- ☐ Repeated shaking with chills
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Chills
- ☐ Muscle pain
- ☐ Sore throat
- ☐ Vomiting
- ☐ Diarrhea

Temperature _____ ☐ Fever Present

Have you worked in facilities or locations with recognized Covid-19 cases? _____

We require each patient to wear a mask, gloves and booties over shoes upon entry into our building. In addition, to wash hands or use an alcohol-based hand sanitizer.

Patient Signature _____Date _____