California Dental Association
1201 K Street, Sacramento, CA 95814
800.232.7645 | cda.org

Covid-19 Patient Screening Form

Patient/Parent/Guardian Names: _____

Screening questions	Date: / / Staff initial:___	Date: / / Staff initial:___	Notes
Do you have a fever or above-normal temperature (>100.4° F)? *Take temperature at appointment.*	☐ No ☐ Yes	☐ No ☐ Yes	
Are you experiencing shortness of breath or having trouble breathing?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a dry cough?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a runny nose?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a sore throat?	☐ No ☐ Yes	☐ No ☐ Yes	
Are you experiencing chills or repeated shaking with chills?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have unexplained muscle pain?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a headache?	☐ No ☐ Yes	☐ No ☐ Yes	
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	

Screening questions	Date: / / Staff initial:____	Date: / / Staff initial:____	Notes
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you been tested for COVID-19 in the last 14 days? *If "no," proceed to next question.*	☐ No ☐ Yes	☐ No ☐ Yes	
***If yes**, what is the result of the testing?* ***If negative,** proceed to next question.* ***If still waiting on results,** schedule appointment after results are known.*	☐ No ☐ Unsure ☐ Positive	☐ No ☐ Unsure ☐ Positive	
Have you traveled more than 100 miles from your home in the last 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	

_____
(**Initial Required**)

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

_____
(**Initial Required**)

By printing the name below, I understand it is equivalent to signing the document and all the information above is true and correct to the best of my knowledge.

Name of Patient Print _____ Date: _____

Name of legal guardian Print _____ Date: _____

Signature _____ Date: _____