COVID-19 QUESTIONNAIRE

Patient Name: ____________________

1. In the past 14-21 days, has the patient, their caregiver, or any close household contact, traveled in the country, internationally or taken a cruise? Y / N

2. In the past 14-21 days, have you or the patient been in contact with any confirmed COVID-19 positive patients? Y / N

3. Are you or the patient experiencing a high fever (100.4 º F or greater), dry cough or any other flu-like symptoms? Y / N

4. Do you or the patient have heart disease, lung disease, kidney disease, diabetes or any auto-immune disease? Y / N

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS PLEASE NOTIFY STAFF IMMEDIATELY.

It is our duty to follow all necessary protocols and guidelines to limit the transmission of any communicable diseases.

I acknowledge all of the above information is true, promise to follow The Bite Dental's present protocol recommendation, accept the potential risk of exposure in our practice to a communicable disease, including but not limited to the COVID-19, and consent to treatment? Y / N

____________________ Signature

____________________ Date

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