Aesthetic Implant & General Dentistry

Patient Screening Form

Date: _____

Use this form to screen patients before their appointment and upon arrival for their appointment.

Patient Name: _____ **Age:** _____ **Staff Screener:** _____

Have you been hospitalized since your last Dental visit? YES ◯ NO ◉

If yes, please explain: _____

Have you had any changes in your medical history since your last dental visit? YES ◯ NO ◉

If yes, please explain: _____

List any new medications: _____ ***Temperature***: _____

Screening Questions:	**Pre-Screen**		**In-Office**	
Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:				
• Fever?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• New Onset of Cough Or Worsening Of A Chronic Cough?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• Shortness of Breath Or Difficulty Breathing?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• Sore Throat or Difficulty Swallowing?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• Decrease or loss of smell or taste?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• Chills, Headaches?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• Unexplained Fatigue/Malaise/Muscle Aches (Myalgias)?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• Nausea/Vomiting, Diarrhea, Abdominal Pain, Pink Eye (Conjunctivitis)?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• Runny nose, nasal congestion without other known cause?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯
• **Are you 70 years of age or older**, experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	**YES** ◯	**NO** ◯	**YES** ◯	**NO** ◯

I understand and accept the increased risk of COVID-19 exposure with treatment at this office due to dental procedure aerosols.

I confirm, that I will advise you if I show signs of COVID-19 within 14 days after my dental visit _____ (Initial)

I confirm that I am **NOT** waiting for the results of a laboratory test for COVID-19 _____ (Initial)

Have you received your **COVID-19 Vaccine as yet?** **Y◯ N◉ .** If yes 1st dose - Date _____ 2nd dose - Date _____

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature of Patient (Parent or Guardian if Minor) Date