

COVID-19 PATIENT QUESTIONNAIRE

If your answer is YES to any of these questions, please contact our office immediately and discuss it with our staff before proceeding with elective dental treatment

Please answer following questions for each patient / child

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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CALL 716-772-7500

THANK YOU!