



Children's Dentistry of AV

41253 12th Street West, #C Palmdale, CA 93551 661.225.9964

COVID-19 Patient Screening Form

Patient/Parent/Guardian Name (s) _____

Please circle the appropriate box for each question:

- | | | |
|---|-----|----|
| 1) Do you have a fever or above-normal temperature (>100.4° F)? | Yes | No |
| 2) Are you experiencing shortness of breath or having trouble breathing? | Yes | No |
| 3) Do you have a dry cough? | Yes | No |
| 4) Do you have a runny nose? | Yes | No |
| 5) Have you recently lost or had a reduction in your sense of smell or taste? | Yes | No |
| 6) Do you have a sore throat? | Yes | No |
| 7) Are you experiencing chills or repeated shaking with chills? | Yes | No |
| 8) Do you have unexplained muscle pain? | Yes | No |
| 9) Do you have a headache? | Yes | No |
| 10) Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? | Yes | No |
| 11) Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days? | Yes | No |
| 12) Have you been tested for COVID-19 in the last 14 days? | Yes | No |
| 13) Have you traveled more than 100 miles from your home in the Last 14 days? | Yes | No |

I attest that all answers given above are true. 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.

Signature _____ Date _____