Coronavirus COVID-19: Patient Risk Survey

Name:						
DOB:						
Verbal Sc	reening:					
2. To	ve you traveled outside of the your knowledge, have you be you experiencing any of the a. Shortness of breath b. Fever c. Cough	een in c	ontact w	rith a COVID-19 patient?	Yes Yes	No No
Visual Scr	eening:					
Please complete visual assessment based on patient's physical appearance:						
• Co	ughing	Yes	No			
	eezing/runny nose	Yes	No			
	le skin	Yes	No			
	tigued	Yes	No			
• Sv	reating	Yes	No			
Patient No	tice to Reschedule:					
seek furthe	r medical evaluation, conside edule your visit at least two w	ering the	Corona om today	ell today. Dr is rec virus, for your health and saf v. For your safety, if you are til you feel better. How does	fety. I am go still not feel	ing to ing well,
Confirmation Calls: Every Patient, One Day Prior to Visit						
you of you highest sta traveled ou to reschedu	r dental appointment onndard of infection control protestide of the U.S. within the pule your visit for a time when Thank you and have a nice	at ocedures past 30 d you are ce day.	and are ays or ar feeling	om (insert practice name). I and we want you to know that committed to your health and experiencing flu like sympletter. We are happy to return	we follow the disafety. If your stoms, we are rn a call to c	ne you have e happy
DISCLAIMER	: This form is provided for information	al purposes	only and d	oes not constitute regulatory or legal ad	vice.	

Last edited: 3/2020