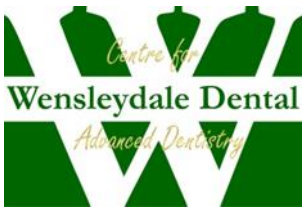

Covid-19 Patient Screening Form

Due to the COVID-19 global pandemic, we ask that you complete this form and provide it to us, prior to entering our practice.

Please be advised that we will not be able to accommodate your appointment without having received this completed form.

In order to safeguard our dental team and the rest of our community, upon arrival and before leaving we will ask that you either wash your hands or use alcohol rub.

If you are experiencing any symptoms related to COVID-19 please do let us know for the safety of our staff and other patients.

		Yes	No	Further Information
Do you have a confirmed diagnosis of Covid-19?				
Are you waiting for Covid-19 test or test results?				
Have you travelled internationally in the last 14 days?				
Have you had contact with someone with a confirmed diagnosis of Covid-19, or been in isolation with a suspected case in the last 14 days?				
Do you have any of the following symptoms?	High temperature or fever?			
	New continuous cough?			
	Sore throat?			
	Shortness of breath?			
	Runny nose?			
	Sneezing?			
	Post-nasal drip?			
	A loss or alteration to taste or smell?			

Patient Name in Capitals: _____

Signature: _____ Date: _____