COVID-19 Health Screening Form

Patient Name: _____ Date: _____

Have you had any of the following within the past 14 days?

YES	NO	
☐	☐	Flu-like or Cold-like symptoms not associated with allergies (including runny nose, body aches and/or sneezing)
☐	☐	Fever and/or chills?
☐	☐	Cough
☐	☐	Shortness of breath
☐	☐	Headaches
☐	☐	Recent changes in the ability to smell or taste
☐	☐	Have you been in close contact with someone who tested positive for COVID-19?
☐	☐	Have you ever been tested for COVID-19?
☐	☐	Does your work involve being in groups of 2 or more, unprotected?
☐	☐	Have you been practicing safe social distancing?
☐	☐	Have you traveled more than 100 miles from your home within the last 14 days?
☐	☐	Have you contacted your doctor's office for any reason? If so, what for:

_____

NOTE: To protect the safety of our staff and our patients, we will be implementing additional Personal Protective Equipment (PPE) and treatment protocols. As such, for many procedures where this is required, we will be implementing a PPE fee of $20 (CDT code D1999). If you have insurance, this fee may or may not be reimbursed by your carrier.

I understand the PPE fee, and attest that the above answers are true and correct to the best of my knowledge:

_____ _____

Signature (Self or Guardian) Date

_____

Print Name