NUERA DENTAL CENTER

Patient Screening Form – Recall Max

Patient Name: _____ Patient Age _____

Who answered: _____ Patient ____ Other (specify) _____

Screening Questions	Pre-screen	In-office
1. Do you have a fever or have felt hot or feverish anytime in the last 10 days? Patient temperature at appointment _____	Yes / No	Yes / No
2. DO you have any of these symptoms: New or worsening Cough? New or worsening shortness of breath? Difficulty Breathing? Sore throat or painful swallowing? Runny nose?	Yes / No	Yes / No
3. Have you experienced a recent loss of taste or smell?	Yes/ No	Yes / No
4. Have you been in contact with any confirmed COVID-19 Positive people, or persons self-isolating because of a determined risk for COVID-19	Yes/ No	Yes / No
5. Have you returned from travel outside of Canada in the Last 14 days?	Yes/ No	Yes / No
6. Have you returned from travel within Canada from a location Known affected with COVID-19 in the last 14 days?	Yes/ No	Yes / No
7. Is your workplace considered high risk?	Yes/ No	Yes / No
8. Are you over the age of 65?	Yes / No	Yes / No
9. Do you have any of the following Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	Yes / No	Yes / No

Patient Signature _____ Date _____

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