innovation drive dental
family & cosmetic dentistry

Patient Screening Form

Patient Name: _____ Patient age: _____
Who answered: ___ Patient ___ Other (specify)
Contact Method: ___ Phone ___ email ___ Other

SCREENING QUESTIONS Pre-Screen
Have you had close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days?
YES /NO

Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?
YES/ NO

Do you have any of the following symptoms:
- Fever
- New onset of cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Difficulty swallowing
- Decrease or loss of sense of taste or smell
- Chills
- Headaches
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain Pink eye (conjunctivitis)
- Runny nose/nasal congestion without other known cause

YES/ NO

Are you 70 years of age or older, experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? YES/ NO

- Any “yes” response must be discussed with the managing dentist immediately.

PRINT PATIENT NAME: _____