DENTISTRY for Children
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Oviedo, Florida 32765
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Pediatricdentistorlando.com

COVID-19 Screening Questionnaire

Patient(s) Name(s)_____

Caregivers name: _____

1. Do you/they have:

-A fever of 100.4 degrees Fahrenheit or higher
-A cough
-Shortness of breath or difficulty breathing

Yes_____
No_____

2. Have you/they traveled in the past 14 days to regions affected by COVID-19?

Yes_____
No_____

3. Have you/they been in close contact with anyone who a has a **confirmed** COVID-19 diagnosis?

Yes_____
No_____

4. Do you/they have heart disease, lung disease, kidney disease or diabetes?

Yes_____
No_____

Positive responses to any of these would necessitate a deeper discussion with the dentist or your physician before proceeding with elective dental treatment. I understand the risks associated with the proposed treatment being performed during the Covid-19 pandemic and consent to such treatment. I have had the opportunity to answer questions as needed.

Signature_____DATE_____/_____/2020