Brett Noorda, DMD, FAGD, MaCSD, FICOI

Comprehensive Sedation & Family Dentistry

Endodontics • Surgery • Implants • Cosmetics • Prosthetics

PATIENT HEALTH SCREENING FORM

	PRE-APPOINTMENT	IN-OFFICE
Do you have a fever, or have you felt hot or feverish recently (14-21 days)?	Yes No	Yes No
Are you having shortness of breath or other difficulties breathing?	Yes No	Yes No
Do you have a cough?	Yes No	Yes No
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No	Yes No
Have you experienced recent loss of taste or smell?	Yes No	Yes No
Have you been or are you regularly in contact with any confirmed COVID-19 positive patients?	Yes No	Yes No
Positive responses to any of the ABOVE require postponing any elective dental treatment. ---------- ***Positive responses to any of the BELOW suggest postponing any elective dental treatment.***		
Is your age over 60?	Yes No	Yes No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No	Yes No
Have you traveled in the past 14 days to any regions highly affected by COVID-19? (as relevant to your location)	Yes No	Yes No

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702.456.7403

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