Kokopelli Family & Cosmetic Dentistry

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Patient Screening Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Do you have fever or have you felt hot or feverish recently (14-21 days)? * ◯ Yes ◯ No

Are you having shortness of breath or other difficulties breathing? * ◯ Yes ◯ No

Do you have a cough? * ◯ Yes ◯ No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? * ◯ Yes ◯ No

Have you experienced recent loss of taste or smell? * ◯ Yes ◯ No

Are you in contact with any confirmed COVID-19 positive patients?
***Patients who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment. ***
◯ Yes ◯ No

Are you over 60 years old? * ◯ Yes ◯ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? * ◯ Yes ◯ No

Have you traveled in the past 14 days to any regions affected by COVID-19? * ◯ Yes ◯ No

A positive response to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment

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Response Date: _____