COVID-19 Screening Questionnaire: for Grant Orthodontics

Patient Name:_____

1) Have you had COVID-19, if so WHEN & have you had a negative test result since being diagnosed?
YES_____NO____or Explain _____

2) Have you had any history of fever in the last 14 days?
YES____ or NO____

3) Have you had any respiratory illness such as cough OR difficulty breathing in the last 14 days? YES___ or NO____

4) Have you OR any household member had any contact with a known COVID-19 patient? YES____ or NO____

5) Have you OR any household member traveled to any international area or areas of suspected community spread in the past 14 days? YES_____ or NO_____

6) Although exposure is unlikely, do you accept the risk and consent to treatment today? **(PLEASE check "YES" to be seen today.)** YES____ or NO_____

Signature_____Date_____

Print Name: **Parent/Guardian**_____