Coronavirus COVID-19

Prior to your appointment, please print this form, answer ALL the questions and bring the completed form with you to your appointment. Your answers will determine if there are any special considerations required for your dental appointment. Thank you.

Patient Name: _____ Age: _____

Who is answering the questions? ___ Patient ___ Other (specify) _____

	Screening Questions	Pre-Screen	In Office
		DATE:	DATE:
1	Do you have a fever or have you felt hot or feverish or had flu like symptoms at any time in the last two weeks ?	Yes ☐ No ☐	Yes ☐ No ☐
2	Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Diarrhea? Fatigue?	Yes ☐ No ☐	Yes ☐ No ☐
3	Have you experienced a recent loss of smell or taste?	Yes ☐ No ☐	Yes ☐ No ☐
4	Have you been in contact with any confirmed COVID-19 positive patients, or persons self isolating because of a determined risk for COVID-19?	Yes ☐ No ☐	Yes ☐ No ☐
5	Have you returned from travel within Canada from a location known to be infected with COVID-19?	Yes ☐ No ☐	Yes ☐ No ☐
6	Is your work place considered to be high risk for COVID-19?	Yes ☐ No ☐	Yes ☐ No ☐
7	Have you been recently tested for COVID-19 and are currently waiting for results?	Yes ☐ No ☐	Yes ☐ No ☐

I understand that the current pandemic requires new asepsis and protocols, and additional steps have been taken to further enhance safety of all patients and staff members. To cover the cost for newly incorporated personal protective equipment (PPE) and infection protocols there will be an additional fee added to your invoice. I understand some insurers may not recognize this yet.

(Signature): _____ Date: _____

To be completed by dental staff prior your appointment

Montreal West Dentistry Staff screener:_____ Date: _____

Montreal West Dentistry 514-484-0521