EPIC DENTAL Spa

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COVID-19 SCREENING

PATIENT NAME

HAS THE PATIENT OR SOMEONE THEY LIVE WITH RETURNED FROM TRAVEL TO A NON-US COUNTRY IN THE PREVIOUS 14 DAYS?

☐ YES ☐ NO

IF YES, WHICH COUNTRY(IES) VISITED

IS THE PATIENT CURRENTLY EXPERIENCING ANY OF THE FOLLOWING FLU-LIKE SYMPTOMS?

☐ FEVER
☐ CHILLS
☐ MUSCLE ACHES
☐ RUNNY NOSE
☐ ABDOMINAL PAIN AND/OR DIARRHEA
☐ LOSS OF SENSE OF TASTE OR SMELL
☐ SORE THROAT
☐ SHORTNESS OF BREATH
☐ NAUSEA / VOMITING
☐ HEADACHE
☐ COUCH

HAVE YOU BEEN IN CLOSE CONTACT WITH SOMEONE WHO HAS BEEN ILL WITH COUGH AND/OR FEVER WITHIN THE PAST 14 DAYS?

☐ YES ☐ NO

DO YOU HAVE ANY OF THE FOLLOWING COVID-19 HEALTH RISK FACTORS:

☐ OVER 65
☐ LUNG CONDITION
☐ IMMUNE COMPROMISED
☐ HEART CONDITION
☐ HIGH BLOOD PRESSURE
☐ DIABETES
☐ PREGNANT

CURRENT PATIENT TEMPERATURE

I HAVE INTERVIEWED THE PATIENT AND CONFIRMED THEY ARE APPROVED TO RECEIVE DENTAL TREATMENT.

EMPLOYEE SIGNATURE

EMPLOYEE NAME

DATE