BELLTOWN DENTAL 2623 Western Avenue | Seattle WA 98121 | 206.441.2774

Patient Screening COVID-19

Patient Name _____

	Pre-appointment		In-office	
	Yes	No	Yes	No
Do you/they have or have had a fever or felt feverish recently (last 14 - 21 days)?	☐	☐	☐	☐
Are you/they having shortness of breath or difficulties breathing?	☐	☐	☐	☐
Do you/they have a cough?	☐	☐	☐	☐
Any flu-like symptoms, such as gastrointestinal upset, headaches, fatigue, runny nose, sore throat, chills, or unexplained muscle pain?	☐	☐	☐	☐
Have you/they experienced recent loss of taste or smell?	☐	☐	☐	☐
Are you/they in contact with any confirmed COVID-19 positive patients? People with flu-like symptoms? (Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment).	☐	☐	☐	☐