PATIENT COVID-19 CHECKLIST

PATIENT INFORMATION

Last Name: ____________________________ First Name: ___________________________ Middle Initial: _______

Date of Birth: __________________________

The health and safety of our patients is our utmost concern. Please be assured that our office will continue to exercise necessary safety precautions to help minimize our patients' exposure to and the potential risk of transmission of any illness, including COVID-19. To help us identify those patients who may be at higher risk of having, or having been exposed to COVID-19, please answer the following questions:

Please check all that may apply.

- ☐ Within the last fourteen (14) days have you had any of the following?
  - A fever over 100.0 degrees Fahrenheit
  - Cough
  - Shortness of Breath/Chest Pain
  - Other flu like symptoms

  If your answer to any of the above was yes, please explain? ____

- ☐ Within the last fourteen (14) days, has anyone in your household exhibited any of the above symptoms?
- ☐ Within the last fourteen (14) days, have you been in close contact with anyone who has any of the above symptoms?
- ☐ Have you been in close contact with anyone who has been exposed to COVID-19 in the past fourteen (14) days?
- ☐ Has anyone in your household been in close contact with anyone who has been exposed to COVID-19 in the past fourteen (14) days?
- ☐ Within the past fourteen (14) days have you or anyone in your household traveled outside of the United States?
  - If so, where? ___________________________________

____
Print Patient Name

____
Patient Signature or
Signature of Parent or Guardian (if Minor)

____
Witness Signature

____
Date of Treatment