ARROWHEAD DENTAL LABORATORY

PATIENT SCREENING FORM

Version: 1.1.2 • **Revision Date:** 5/4/2020

Email Form

Patient Name: _____
Referring Dental Practice: _____
Dentist Name: _____
Date Form Completed: _____

Do you have a fever or have you felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☐ Yes ☐ No
Are you in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No
Is your age over 60?	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No

Please call 1.800.800.7200 to get clearance for entry if you responded "Yes" to any of the questions above.