Patient: _____________________

Date Of Appointment __________

Temperature at appointment day: __________

In an effort to protect our patients and staff from illness, we are screening ALL patients and staff. Please answer the following:

A) Within the past 14 days: (date of the 24-hour call:__________)		**B) Today:**
I have tested positive for COVID-19 or currently waiting on test results.	YES NO	YES NO
I have been around people who have tested positive for COVID-19 or are waiting on test results.	YES NO	YES NO
I have been sick with COVID-19-like symptoms such as coughing, cold, or flu.	YES NO	YES NO
I have had a fever.	YES NO	YES NO
I have had nausea and vomiting.	YES NO	YES NO
I have had shortness of breath or difficulty breathing.	YES NO	YES NO
I have had chills, muscle pain, headache, sore throat.	YES NO	YES NO
I have had loss of taste or smell.	YES NO	YES NO
I have returned from overseas travel or a state that is a hotspot for COVID-19.	YES NO	YES NO

IF YOU MARKED YES TO ANY OF THE ABOVE QUESTIONS, WE NEED TO POSTPONE YOUR VISIT FOR ATLEAST 14 DAYS FROM THE DAY YOU HAVE BEEN SYMPTOM-FREE.

PLEASE NOTE: The Arkansas Department of Health has mandated dental offices to call patients 48-72 hours after aerosol-producing dental procedures. Initial here ______

Patient Signature: ___________________________

------------------------------**OFFICE USE: 48-72 Hours Post Aerosol Producing Procedures**--------------------------

Patient was contacted about COVID-19 symptoms to determine if dentists and staff have been exposed.

EFD Staff:________________________ Date of call:______________