Walnut Grove Family Dental
604-882-0887

Patient Screening Form

Appointment Date:___________________________ Patient Name:________________________

Phone Number:__________________________________ Age:_____

Please complete this form the day of your appointment and bring with you to your appointment.

Screening Questions	Please Circle YIN
1. Do you have a fever or have you felt hot or feverish anytime in the last two weeks? Patient temperature at appointment:	YES NO
2. Do you have any of these symptoms: Dry cough? Headaches? Difficulty breathing? Sore throat or painful swallowing? Runny nose/Sneezing/Post-nasal drip? Chills? Muscle aches? Fatigue?	YES NO
3. Have you experienced a recent loss of smell or taste?	YES NO
4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?	YES NO
5. Have you returned from travel outside of Canada in the last 14 days?	YES NO
6. Have you returned from travel within Canada from a location known affected with COVID-19?	YES NO
7. Is your workplace considered high risk for COVID-19 exposure?	YES NO
8. Have you tested positive for COVID-19?	YES NO
9. Are you waiting for the results of a test for COVID-19.	YES NO
10. Are you required to self-isolate for 14 days?	YES NO

Patient Vulnerability

11. Are you over the age of 70?	YES NO
12. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	YES NO

Patient Acknowledgment of Covid-19 Pandemic Risk

-I understand there is currently a health pandemic associated with Covid-19 and the novel Coronavirus

-I understand public health authorities have recommended maintaining social distancing of at least 2 Meters (6 feet) and it is not possible to maintain this distance while receiving dental treatment

-I understand that oral surgery/dental procedures can create water and /or blood spray, and that there may be an elevated risk of contacting and spreading the novel Coronavirus in a dental office

-I hereby consent to have dental treatment completed during the Covid-19 pandemic.

Signature of Patient: ____ Date:____________________