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 Y/N
1. Do you have any of these symptoms: Fever or chills? Cough? Loss of sense of smell or taste? Difficulty breathing?	YES NO
2. Do you have a sore throat? Loss of appetite? Extreme fatigue or tiredness? Headache? Body ache? Nausea, vomiting or diarrhea?	YES NO
3. Have you returned from travel outside Canada in the last 14 days?	YES NO
4. Have you had close contact with anyone diagnosed with lab-confirmed or suspected COVID-19?	YES NO
5. Have you lived or worked in a setting that is part of a COVID-19 outbreak?	YES NO
6. Have you been advised to self-isolate or quarantine at home by public health?	YES NO
7. Is there any additional information you'd like us to have?	

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:_____