integral Denture CENTRE

COVID-19 PATIENT SCREENING FORM

Our records indicate you have an upcoming appointment with our office on _____.

Due to the COVID-19 global pandemic, we ask that you complete this form prior to arriving at our office and return it to us via email at (office email address).

We will not be able to accommodate your appointment without having received this before you arrive for your appointment.

In order to safeguard our denture office and the rest of our community, we ask that you arrive at the office wearing a face mask. You will not be allowed entry without a face mask. If we have an adequate patient protective equipment (PPE) supply, we will provide you with a new face mask before you leave our office.

If you are experiencing any symptoms related to COVID-19, we ask that you do not come to our office at this time. Symptoms are indicated below:

Cough, shortness of breath, or difficulty breathing

Or any two of the following:

Fever
Chills
Repeated shaking with chills
Muscle pain
Headache
Sore throat
New loss of taste or smell

This list is not all inclusive.

Please consult your medical provider if you have any other severe symptoms that concern you.

If you develop any of the following symptoms (warning signs) for COVID-19, seek emergency medical attention immediately:

Trouble breathing
Persistent pain or pressure in the chest
New confusion or inability to arouse
Bluish lips or face

If you are unable to print this form and email it, please copy and paste the questionnaire into a composed email and send it to the email address above.

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PATIENT QUESTIONNAIRE

1. Have you traveled anywhere recently that are locations of disease outbreak?

2. Have you been in contact with anyone who was sick?

3. Have you attended any large group functions?

4. Have you had any of the following symptoms within the last two weeks: fever, fatigue, dry cough, altered taste, altered smell, trouble breathing, productive cough (mucous in cough), or muscle pain?

5. Have you previously had the SARS-COV-2 virus (novel coronavirus)? If so, did you test positive and what test were you administered?

6. Are you over the age of 65 and/or have pre-existing health conditions related to the following: diabetes, chronic lung disease or asthma, serious heart condition, immunocompromised, or chronic kidney or liver disease?

We thank you for your cooperation and will contact you if we need further information.

Thank you,

For Integral Denture Centre

[Name of Denturist]