**COVID-19 Screening and Consent Form**

**Do you have flu-like symptoms including:**

**Fever Yes No**

**New onset of cough Yes No**

**Worsening chronic cough Yes No**

**Difficulty breathing Yes No**

**Sore throat Yes No**

**Difficulty swallowing Yes No**

**Decrease or loss of sense of taste and smell Yes No**

**Chills Yes No**

**Headaches Yes No**

**Unexplained fatigue/malaise/muscle aches (myalgias) Yes No**

**Nausea/vomit/diarrhea/abdominal pain Yes No**

**Pink eye (conjunctivitis) Yes No**

**Runny nose/nasal congestion without other known cause Yes No**

**Rash of unknown origin? Yes No**

**Are you positive for the coronavirus ? Yes No**

**Are you waiting for results of a coronavirus tests ? Yes No**

**Have you returned from travel in the last 14 days? Yes No**

**Have you had close contact with a confirmed or probable case of COVID-19? Yes No**

**Have you had close contact with a person with acute respiratory illness Yes No**

**who has returned from travel to an impacted area?**

**Do you understand that there is a possibility, although very small, Yes No**

**that you could be at risk of exposure to COVID-19 at this office?**

**Do you consent to dental treatment by Dr.Roya Khoshsar and her associates**

**understanding the risks during this COVID-19 outbreak? Yes No**

**Patient name (print) .**

**Signature Date .**

**(FOR OFFICE USE)**

**Temperature \_\_\_\_\_\_\_\_ Unusual (misc.) symptoms Y / N**

**Cough Y / N**

**Breathing normal Y / N**

**Oxygen % \_\_\_\_\_\_\_ ( staff signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ )**