COVID-19 PATIENT SCREENING FORM

 Due to the COVID-19 global pandemic, we ask that you complete the PATIENT QUESTIONNAIRE form prior to arriving at our office and return it to us via email at office@franklinavenuedentalcare.com

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

A form will be text-messaged to you at your appointment confirmation if your cell phone number is on file with our office.

In order to safeguard our dental 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

 Gastrointestinal symptoms such as diarrhea, or upset stomach

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.**

**Stay Safe and Healthy!**

Dr Alexander Barsky and staff.

 **Patient Questionnaire**

 Please circle a correct response

1. Have you been in contact with anyone who was sick with COVID-19 within the last 4 weeks?

Yes NO

1. Have you attended any large group functions?

YES NO

1. 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? (Please circle any symptom you have experienced)

 YES NO

1. Have you previously had the COVID-19 virus (novel coronavirus)? If so, did you test positive and what test were you administered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES NO

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

YES NO

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

Dr Alexander Barsky and staff