COVINGTON FAMILY DENTAL

COVID-19 SCREENING FORM

YES	NO	
☐	☐	Do you/they have a fever (100.4 F) or have you/they felt hot or feverish recently (14-21 Days)?
☐	☐	Are you/they having shortness of breath or other difficulties breathing?
☐	☐	Do you/they have a cough?
☐	☐	Any other flu-like symptoms, such as gastrointestinal upset, headache, fatigue?
☐	☐	Have you/they experienced recent loss of taste or smell?
☐	☐	Are you/they in contact with any confirmed COVID-19 positive patients?
☐	☐	Have you/they traveled in the past 14 days to any regions affected by COVID-19?
☐	☐	Do you/they have a pending COVID-19 test and are awaiting results?

***If you answered yes to ANY of these questions, please contact our front office prior to your appointment at 253-630-5500 or admin@covingtonfamilydental.com**