Dr. Peter Blauzvern / Dr. Tascha Fuchs

Patient Pre-Appointment Screening Form:

Print Name:_____ **Signature:**_____ _

Date:_____ **Please circle Yes or No:**

Do you have fever now, or have you felt hot/feverish in the last 14-21 days? Yes No

Do you have shortness of breath or difficulties breathing? Yes No

Do you presently have a cough? Yes No

Do you have any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue? Yes No

Have you experienced recent loss of taste or smell? Yes No

Are you or have you been in contact with any confirmed COVID-19 positive patients? Yes No

Have you had contact with people who are well, but they have a sick family member at home with COVID-19? Yes No

Do you have past or present heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders? Yes No

Have you traveled in the past 14 days to regions affected by COVID-19? Yes No

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Positive responses to these questions would likely indicate a re-evaluation of performing elective procedures at the present time. Emergency treatment: i.e., fractured tooth, pain, bleeding, or swelling would still be available to all patients.