South Shore DENTISTRY
Comprehensive. Compassionate. Convenient.

PATIENT PRE-SCREENING QUESTIONNAIRE

Name: _____ Date: _____

Phone Number: _____ Email address: _____

Please answer honestly:

YES **NO** I have been in contact with someone who I know has been exposed to the virus?

YES **NO** I have been tested for COVID-19? If yes, date tested: _____

My test was: **NEGATIVE** **POSITIVE**

YES **NO** I have had a fever in the past 72 hours?

YES **NO** I have a cough?

YES **NO** I have other symptoms of respiratory illness (nasal congestion, shortness of breath, sneezing, sore or scratchy throat, etc.)

YES **NO** I have been out of the country in the past 14 days?

Countries visited: Dates:

_____ _____ to _____

_____ _____ to _____

If you answered **YES** to any of the above, please reschedule your appointment when you are well. Thank you for helping us keep out patients and staff healthy and safe.

I do not have any of the above symptoms, nor have I traveled internationally.

Signature: _____ Date: _____