Spangler, Rohlfing & Lambert Pediatric Dentistry
COVID-19 Screening Form

Patient Name: ____

Completed by: **Mom / Dad / Patient / Other**: ______________

COVID-19 SCREENING QUESTIONS:

1. Has the patient or anyone in contact with the patient experienced signs or symptoms of COVID-19 in the past 21 days such as cough, fever, difficulty breathing, sore throat, nausea, fatigue, headache, runny nose or loss of taste and/or smell? **YES | NO**

   If yes, please specify ____

2. Has the patient or anyone in contact with the patient traveled outside of the country in the past 21 days? **YES | NO**

   If yes, where? ____

3. Has the patient, caregiver, or other household member been tested for COVID-19 in the past 21 days? **YES | NO**

   If yes, what was the result? ______________________________________

4. Has the patient or caregiver come in contact with a person who is COVID-19 positive or a person who has suspected exposure to COVID-19 in the past 21 days? **YES | NO**

COVID-19 CONSENT FOR TREATMENT:

1. As the parent/legal guardian or patient, I consent to dental treatment during the COVID-19 pandemic **YES | NO**

2. As the parent/legal guardian or patient, I consent to comply with the new office COVID-19 policies (listed at happykidssmiles.com) **YES | NO**

Parent/Legal Guardian
Or Patient Signature ____ **Date** ______________