Sein H. Siao, DMD & Associates, PC

NAME:_____ DATE OF BIRTH:_____

SCREENING QUESTIONAIRE:

- Have you been diagnosed with COVID-19 in the past 14 days? YES___ NO___
- If yes, have at least 3 days passed since recovery and 7 days passed since first symptoms? YES___ NO___
- Have you been diagnosed as a "Person under Investigation" for COVID-19 now or in the past 14 days? YES___ NO___
- Have you had close contact with any COVID-19 positive patients (past 14 days)? YES___ NO___
- Do you have fever or have you felt hot or feverish recently (14-21 days)? YES___ NO___
- Do you have a cough, shortness of breath or difficulty breathing *(not related to a chronic condition)*? YES___ NO___
- Any other flu-like symptoms, such as: Gastrointestinal upset, headache, sore throat, shivering/chills, runny/stuffy nose, diarrhea, nausea/vomiting, muscle aches, new rash, new foot sores? YES___ NO___
- Have you experienced recent loss of taste or smell? YES___ NO___
- Have you travelled outside of Massachusetts (past 14 days)to locations other than: *Rhode Island, Connecticut, Vermont, New Hampshire, Maine, New York or New Jersey*? YES___ NO___

YOU ARE RECEIVING DENTAL CARE DURING THE EVENTS OF A COVID-19 NATIONAL EMERGENCY. PLEASE BE ADVISED THAT THERE MAY BE RISKS IN BEING IN THE PROXIMITY OF DENTISTS, PATIENTS, OR STAFF. WE ARE TAKING PRECAUTIONS TO LIMIT THE SPREAD OF DISEASE, YET THERE IS STILL A POSSIBILITY OF TRANSMISSION.

SIGNED:_____

REVIEWED BY:_____

DATE:_____