Capital Region
Complete Dental Care
& Implants
Solutions to
Your Dental Concerns

Pre-Appointment Screening Questions

1. Do you or have you had any flu-like symptoms in the last 14 days? ___YES ___NO

- Cough
- Shortness of Breath
- Or at least two of these symptoms:
  - o Fever
  - o Chills
  - o Repeated shaking
  - o Fatigue
  - o Muscle aches
  - o Vomiting
  - o Headache
  - o Sore throat
  - o New loss of taste or smell
  - o Malaise
  - o Nausea
  - o Diarrhea

2. Are you awaiting results of a lab test for COVID-19? ___YES___NO

3. Have you tested positive for COVID-19? ___YES ___NO When? _____

4. Have you or a family member previously been asked to self-isolate or self-quarantine in the past 14 days?
   ___YES ___NO

5. Have you had close contact to an individual diagnosed with COVID-19 infection in the past 14 days?
   ___YES ___NO

6. Have you traveled in the past 14 days to a region with high rates of COVID-19 disease activity?

   ___YES ___NO

If yes to any of the above questions, delay elective treatment for 14 days, then re-evaluate.

SIGN_____ PRINT_____DATE_____