

Ann Arbor Pediatric Dentistry

Patient and Parent/Guardian COVID Screening Form

Patient Name: _____ DOB: _____

Parent or Guardian Name – Pre-App: _____

Parent or Guardian Name – In-Office App: _____

	Pre-App	In-Office
	Date:	Date:
	Staff Initials:	Staff Initials:
Do you/they have a fever or have felt hot or feverish recently (14-21 days)? A fever is any temperature of 100.0 degrees F or higher.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Child's Temp: _____ Guardian's Temp: _____
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as a gastrointestinal upset, headache, or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they/any family member in the house ever tested positive for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days to any regions affected by COVID-19	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

A positive response to any of these questions would indicate a deeper discussion with the dentist before proceeding with elective dental treatment. Please bring this paperwork to the DDS before proceeding with confirming an appointment or starting treatment on a patient.