Screening Questionnaire

As the coronavirus disease 2019 (COVID-19) outbreak continues to evolve and spreads globally. To prevent the spread of COVID-19 and reduce the potential risk of exposure to our staff and patients, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time.

Patient's Name: _____

Personal Phone Number (mobile/home): _____ / _____

Temperature taken by Touchless Thermometer: _____

Self-Declaration by patient

1. Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days? ☐ Yes ☐ No

2. Have you had a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19 ☐ Yes ☐ No

3. Do you have any of the following symptoms: ☐ Yes ☐ No
   - Fever
   - New onset of cough
   - Worsening chronic cough
   - Shortness of breath
   - Difficulty breathing
   - Sore throat
   - Difficulty swallowing
   - Decrease or loss of sense of taste or smell
   - Chills
   - Headaches
   - Unexplained fatigue/malaise/muscle aches
   - Nausea/vomiting, diarrhea, abdominal pain
   - Pink eye
   - Runny nose/nasal congestion without other known cause

4. If you are over 70yrs of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? ☐ Yes ☐ No

If the answer is "Yes" to any of the above questions, access to our office will be denied.

OFFICE USE ONLY

Signature (Staff): _____ Date: _____

(Circle One): NEGATIVE POSITIVE

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Patient Acknowledgement:
COVID-19 Pandemic Emergency Dental Risk

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

1 understand the novel coronavirus causes the disease known as COVIO-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus ***may not show symptoms and still be contagious***. For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible. _____ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize it is ***not possible to maintain this distance while receiving dental treatment***. _____ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____ (initial }

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, ***that I have an elevated risk of contracting the novel coronavirus simply by being in the dental office***.
_____ (initial)

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: (i) fever, (ii) new or worsening cough, (iii) sore throat, (iv) runny nose or (v) headache. _____ (initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative.
_____ (initial) If applicable, approximate date of test:

I confirm that I am not waiting for the results of a test for COVlD-19. _____ (initial)

l confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. _____ (initial)

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to have emergency surgical/dental treatment completed during the COVID-19 pandemic.

SIGNATURE OF PATIENT: _____ Date: _____