# Patient Pre-Screening Interview

COLUMBIA SMILES FAMILY DENTISTRY

**Patient Name:**

◯ Updated Contact information: cell number _____

◯ Updated insurance information

◯ Reviewed check-in and out procedures

◯ Pre-screen questionnaire sent

◯ Informed consent signed

◯ Updated health history/med/allergies

| | Pre- Appointment | In- Office |
|---|---|---|
| *Have you, anyone you live with, or someone accompanying you today have a fever above 100.4 F in the last 14-21 days?* | ☐Yes ☐No | ☐Yes ☐No |
| Are you having shortness of breath or other difficulties breathing including chest pain or tightness? | ☐Yes ☐No | ☐Yes ☐No |
| Do you have a cough? | ☐Yes ☐No | ☐Yes ☐No |
| Are you having any other cold or flu-like symptoms, such as gastrointestinal upset, headache, sore throat, or fatigue? | ☐Yes ☐No | ☐Yes ☐No |
| Have you experienced recent loss of taste or smell? | ☐Yes ☐No | ☐Yes ☐No |
| Have you, anyone you live with, or someone accompanying you today been in contact with, suspected, or sympathetic to and tested positive for COVID-19? *Patients who are well but who have a sick family member at home with COVID-19 must reschedule their appointment* | ☐Yes ☐No | ☐Yes ☐No |
| Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? | ☐Yes ☐No | ☐Yes ☐No |
| Have you or anyone residing with you, traveled outside of the country or into Maryland from another state in the past 21 days? | ☐Yes ☐No | ☐Yes ☐No |
| If you have had to medically quarantine, what was the last day of quarantine and for what medical necessity_____ | | |

**Positive responses to any of these will indicate a deeper discussion with the dentist before proceeding with elective dental treatment.** Refer for testing of COVID-19 if patient is exhibiting any signs. See the list of State and Territorial Health Department Websites for your specific area's information.

◯ **In Office temperature _____**