BELLA TERRA DENTAL

COVID-19 Screening Form

Patient Name: _____DOB: _____Today's Date: _____

Please circle YES or NO to the following questions:

1. Have you or traveled outside of the USA in the last 14 days

YES NO

2. Have you traveled within the USA in the last 14 days?

YES NO

3. Have you been on a cruise ship in the last 14 days

YES NO

4. Have you and/or the patient been in close contact with anyone who has traveled domestically or internationally in the last 14 days

YES NO

5. Have you attended any events or gatherings with more than 100 people

YES NO

6. Have you been in close contact with a person known to have the 2019 Novel Coronavirus

YES NO

7. Have you and/or the patient been asked to self-quarantine?

YES NO

8. Do you currently have fever or lower respiratory symptoms such as a cough or shortness of breath?

YES NO

9. Do you have a new onset of cold symptoms such as a cough and runny nose?

YES NO

For more information on the COVID-19 virus and things you can do to mitigate it's spread, please visit CDC.gov/coronavirus.

Patient's Name: _____

Patient's Signature: _____Date: _____
(Parent/Guardian's Signature if patient is a minor)

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