VISTA FAMILY DENTISTRY

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Patient Safety Screening COVID-19

Staff Name:

Patient Name:

Appointment Date/Time:

Have you had contact with anyone with Confirmed COVID-19/quarantined in the last 14 days?
YES NO

Have you had Runny Nose, Sore throat, Cough or Fever in last 14 days?
YES NO

Are you currently experiencing fever, difficulty breathing, cough or any flu like symptoms?
YES NO

Have you or someone you are in close contact with travelled to any foreign country in last 14 days?
YES NO

If Yes, where? _____

Patient Signature

Your Safety is important to us!