AZAR ORTHODONTICS PATIENT SCREENING

PRIOR TO APPOINTMENT

Please complete within 24 hours of appointment date and bring in to appointment

Patient Name:

DOB:

Phone Number:

-Presently, or in the past 14 days, has patient had any respiratory symptoms (coughing, shortness of breath)? Y N

-Presently, or in the past 14 days, has the patient had a fever of 100.4 F or greater? Y N

-Is the patient currently taking any Tylenol or Ibuprofen? Y N

-Have you traveled outside of the local area in the past 14 days? Y N

If so, where and when?

-Have you been in direct contact with anyone with COVID-19 or respiratory symptoms? Y N

If so, when?

I hereby certify the above statements are true to the best of my ability.

_____ Date_____