ANDREW WHEATLEY, DDS
AT TECUMSEH RIDGE DENTAL

COVID-19 Patient Questionnaire

Name:_____Birthday: _____
Phone number: _____
Address: _____
E-Mail: _____
Are we going to be filing insurance for you?
Insurance company: _____
insurance ID#_____
insurance company phone # on back of card_____
Are you in pain? **YES / NO**
On a scale of 1 to 10 (one being no pain and 10 being the worst pain you can imagine), what's your pain level?_____

The CDC recommends health care facilities, including dental offices, evaluate patients before they arrive for their appointment to screen for anyone who may be ill with, or who has been exposed to, the new coronavirus (COVID-19).

1) Do you have a fever or have you experienced a fever within the past 14 days? **YES / NO**

2) Does anyone close to you have a fever or have they experienced a fever in the past 14 days? **YES / NO**

3) Have you or anyone close to you experienced a recent onset of respiratory problems, such as a cough or difficulty in breathing within the past 14 days? **YES / NO**

4) Have you or anyone close to you experienced flu-like symptoms within the past 14 days such as:
   - Cough – wet or dry **YES / NO**
   - Fever **YES / NO**
   - Shortness of Breath **YES / NO**
   - Sore Throat **YES / NO**
   - Muscle/Body Aches **YES / NO**
   - Nausea/Vomiting **YES / NO**
   - Fatigue **YES / NO**
   - A recent lack of taste or smell **YES / NO**

5) Have you, or anyone you have come into contact with, travelled out of state within the last 14 days? **YES / NO**

6) Have you been traveling on an airplane or any other form of mass transit? **YES / NO**

7) Have you, or anyone you have come into contact with, travelled outside of the country in the last 21 days? **YES / NO**

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8) Have you come into contact with anyone who has tested positive for COVID-19? **YES / NO**

9) Have you been tested for COVID-19, with either a positive or negative result? **YES / NO**

10) Do you have an autoimmune disorder or are you on an immune-suppressing medication or steroids? Or are you the primary caregiver of anyone suffering from immune-deficiencies? **YES / NO**

11) Are you diabetic? **YES / NO**

12) Have you been diagnosed or treated for a heart or lung related disease within the past 12 months? **YES / NO**

13) Have you been diagnosed or treated for cancer in the past 12 months or are you the primary caregiver of somebody being treated for cancer? **YES / NO**

14) Do you currently smoke or vape or have you stopped those activities within the past 2 years? **YES / NO**

15) Persons over 65 are at a higher risk. Are you above 65? **YES / NO**

To assure the health and safety of all our patients and employees, please consent to a screening for COVID-19 symptoms prior to your treatment.

I, _____, consent to a screening prior to treatment.

I,_____, consent to treatment by Dr. Wheatley, DDS and his Team.

I,_____, certify that all the above answers are true.

_____ _____
Patient or guardian signature Date

_____ _____
DDS signature Date