SIERRA Oral & Facial Surgery

Dr. Ryan Falke

Patient Screen Form

Patient Name: *

First Name Last Name

DOB *

Month Day Year

Pre-Screening Date *

Month Day Year

When is the patient's scheduled appointment? *

Month Day Year

PRE-APPOINTMENT SCREENING:

	Yes	No
Do you/they have a fever or have you/they felt hot or feverish recently? (14/21 days)	○	○
Are you/they having shortness of breath or other difficulties breathing?	○	○
Do you/they have a cough?	○	○
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	○	○
Have you/they experienced recent loss of taste or smell?	○	○
Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	○	○
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	○	○
Have you/they traveled in the past 14 Days to any regions effected by COVID-19? (As relevant to your location)	○	○

Are you/they over the age of 60?	○	○

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	Yes	No
Do you/they have a fever or have you/they felt hot or feverish recently? (14/21 days)	○	○
Are you/they having shortness of breath or other difficulties breathing?	○	○
Do you/they have a cough?	○	○
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	○	○
Have you/they experienced recent loss of taste or smell?	○	○
Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	○	○
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	○	○
Have you/they traveled in the past 14 Days to any regions effected by COVID-19? (As relevant to your location)	○	○
Are you/they over the age 60?	○	○

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with effective dental treatment.

If under 18, parent/guardian signature OR Patient Signature:

_____

SOFS Team Member Witness:

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