Aquidneck Avenue Family Dental

COVID-19 Patient Screening Form

PATIENT NAME: DATE:

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST 14 DAYS?	YES	NO
COUGH		
SHORTNESS OF BREATH OR DIFFICULTY BREATHING		
FEVER		
CHILLS		
MUSCLE PAIN		
SORE THROAT		
HEADACHE		
NAUSEA OR VOMITING		
DIARRHEA		
RUNNY NOSE OR STUFFY NOSE		
RECENT LOSS OF TASTE OR SMELL		
IF YES WAS ANSWERED TO ANY OF THE ABOVE, WE WILL NEED TO REBOOK YOUR APPOINTMENT FOR AFTER 14 DAYS		

RISK FACTORS

	YES	NO
Have you been in close contact (less than six feet) with anyone with COVID-19 or symptoms of COVID-19 in the past 14 days?		
Have you traveled anywhere outside the 50 United States in the past 14 days?		
Have you traveled to Rhode Island from another state for a non-work-related purpose in the past 14 days?[1]		
Have you been directed to quarantine or isolate by the Rhode Island Department of Health or a healthcare provider in the past 14 days? If so, when does/did your quarantine or isolation period end?		
IF YES WAS ANSWERED TO ANY OF THE RISKS FACTORS ABOVE, WE WILL NEED TO REBOOK YOU APPOINTMENT FOR AFTER 14 DAYS.		
PLEASE MAKE YOUR PROVIDER AWARE UPON ARRIVAL IF YOU HAVE HEART DISEASE, LUNG DISEASE, KIDNEY DISEASE, DIABETES OR ANY AUTO-IMMUNE DISORDERS.		