Coronavirus Disease (COVID – 19) Patient Triage Plan

Patient Screening Prior to Visit

Patient Name:	DOB	
Home Address:		
Phone Number:		
Has anyone in your household experienced any respiratory symptoms in the past 14 days? (Fever, Cough, Shortness of Breath)	☐ Yes	☐ No
List symptoms:		
Has anyone in your household traveled outside of the US in the past 14 days?	☐ Yes	☐ No
If yes, please list location:		
Areas of concern change daily and will be assessed based on the most current CDC guidelines.		
Has anyone in your household ever been in close contact (within 6 feet) of a person with COVID-19/Coronavirus?	☐ Yes	☐ No
If yes, please explain interaction and include the date:		
Information reviewed by:		
For positive responses to travel, close contact, or symptoms: **- Please reschedule your dental appointment.** **- Please contact your physician as well as local or state health departments.**		