Fiser Family Dental

COVID-19 Screening Questionnaire

1) Have you returned from overseas travel or from states/metropolitan areas considered hot spots for COVID-19 spread within the last 14 days?

2) Have you had a fever of 100.4°F+ or greater in the past 14 days?

3) Have you had or currently have any symptom or combination of symptoms associated with COVID-19 such as cough, shortness of breath, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat new loss of taste or smell?

4) Have you been in contact with any persons who have tested positive for COVID-19 or have you yourself tested positive for COVID-19 within the past 14 days?

I hereby acknowledge that I have answered the following questions truthfully and to the best of my knowledge.