Patient Screening Form

ADA

LAKE OSWEGO PERIODONTICS & IMPLANT DENTISTRY
Matt J. Hoidal, D.D.S., M.S., P.C.

Patient Name: ____ Patient Temperature: ___________________

Patient Advisory and Acknowledgment - Receiving Dental Treatment During the COVID-19 Pandemic

In order to reduce the risk of spreading COVID-19, we will be asking you a number of screening questions before your appointment with our office. For the safety of our staff, other patients, and yourself, please be truthful and candid in your response to these questions. Our office follows the infection control recommendations made by the American Dental Association (ADA), the U.S. Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), the Oregon Health Authority (OHA), and the Oregon Board of Dentistry (OBD). We are monitoring the recommendations of these agencies to remain up-to-date on any new recommendations or guidance that may be issued. While our office complies with the CDC and OSHA recommendations & guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. We are monitoring our staff daily with a temperature check & pre-screening questions.

Please answer YES or NO to the following questions:

Are you currently awaiting the test results of a COVID-19 test
(or any family member you reside with awaiting a test results)? ____ Yes ____ No

Are you in contact with any confirmed COVID-19 positive patients? ____ Yes ____ No
*(*if you are feeling well but have a sick family member at home with COVID-19 you should postpone elective treatment)*

Do you have a fever or have you felt hot or feverish recently (within the last 14 – 21 days)? ____ Yes ____ No

Have you experienced a recent loss of taste or smell? ____ Yes ____ No

Are you having shortness of breath or other breathing difficulties? ____ Yes ____ No

Do you have a dry cough? ____ Yes ____ No

Do you have a runny nose? ____ Yes ____ No

Do you have a sore throat? ____ Yes ____ No

Do you have sneezing, watery eyes, and/or sinus pain/pressure
that is unusual and not related to seasonal allergies? ____ Yes ____ No

Do you have or have you experienced any other flu-like symptoms, such as:
gastrointestinal issues, headache, or fatigue, within the last 14 – 21 days? ____ Yes ____ No

Do you have any underlying medical concerns, such as:
heart disease, lung disease, kidney disease, diabetes, or any auto-immune disease? ____ Yes ____ No

Within the last 14 days, have you traveled within the United States or to any foreign country? ____ Yes ____ No

______________________________ ______________________ ______________
Patient Signature (or legal guardian if minor) relationship to patient Date