Artin Sakhaee D.D.S
Michael Baharestani D.D.S
Melvyn Topel D.D.S
Iren Sedaghatpour D.D.S
283 Commack Road STE 120
Commack, NY 11725
CommackDentalDesign@gmail.com
CommackDentalDesign.com

COVID Patient Screening Form

Patient Name:________________________________ **Birthdate**________________________

Do you have a fever or have you felt hot or feverish recently (14-21 days)? Yes No

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

Do you have a cough? Yes No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? Yes No

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

Are you in contact with any confirmed COVID-19 positive patients? Yes No
Patients who are well but who have a sick family member at home
with COVID-19 should consider postponing elective treatment.

Are you over the age of 60? Yes No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? Yes No

Have you traveled in the past 14 days to any regions affected by COVID-19? Yes No
(as relevant to your location)

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

For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Signature____ Date:____________________