CF Smiles
COSMETIC & FAMILY DENTISTRY
Constantin Fiacos, DMD

Patient Name_____ Date_____

1) Do you have fever or have you felt hot or feverish recently (14-21 days)?

____Yes ____No

2) Are you having shortness of breath or other difficulties breathing?

____Yes ____No

3) Do you have a cough?

____Yes ____No

4) Any other flu-like symptoms, such as stomach issues, headache, or fatigue?

____Yes ____No

5) Have you experienced recent loss of taste or smell?

____Yes ____No

6) Are you in contact with any confirmed or suspected COVID-19 positive patients?

____Yes ____No

7) Have you traveled in the past 14 days?

____Yes ____No

Adapted from the ADA COVID-19 Guidelines.