Elliot R. Davis D.D.S.

COVID-19: Safety Screening Checklist

1. How do you feel today (1-5)?
    a. 1 = Terrible
    b. 2 = Uncomfortable
    c. 3 = Fair
    d. 4 = Pretty Good
    e. 5 = Excellent
    f. Please circle: 1 2 3 4 5

2. Have you ever been tested for COVID-19
    □ No
    □ Yes
    □ Not sure
    □ Other _____

3. If you were tested, list each date you were tested and the result "positive (+), negative (-)."
    □ ____/____/_____ + / - / awaiting result
    □ ____/____/_____ + / -
    □ ____/____/_____ + / -

4. Do you believe you may have been exposed to COVID-19 in the past 14 days?
    □ No
    □ Yes
    □ Not sure
    □ Other _____

Elliot Davis, D.D.S. o (212) 645-9255 c (917) 494-7494 DrDavis@TheManhattanDentist.nyc

5. During the past 3 days, please check each symptom which you have had.
   - □ Altered sense of smell
   - □ Altered sense of taste
   - □ Breathing difficulty
   - □ Chills
   - □ Coughs
   - □ Diarrhea
   - □ Fever □ ____ ° F
   - □ Headache
   - □ Muscle pain
   - □ Rash
   - □ Shakes
   - □ Shortness of breath
   - □ Sniffles
   - □ Sore throat
   - □ Tingling in toes or fingertips
   - □ Other _____

6. (____) *Please initial.* I read and understand English and all these answers were truthful.

7. (____) *Please initial.* I understand that there will be additional screening once I enter the office.

_____	_____
Patient Name *(print)*	*(signature)* Patient/Personal Representative
_____	_____
Email address	Date
_____	_____
Text / mobile phone number	Signature

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