a | a aschheim & arteaga
cosmetic, restorative and implant dentistry

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Notes: **Phone:**

Patient Name: **Cell Phone:** **e-Mail:**

ONLY FILL OUT *PRE-APPOINTMENT COLUMN* UNLESS TOLD OTHERWISE *Red Boxes are Required Fields*	PRE APPOINTMENT Date:	IN OFFICE Confirmation Date: By:
Do you have fever, or have felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	☐ Yes ☐ No	☐ Yes ☐ No
Do you require an essential escort accompany you to the office.	☐ Yes ☐ No	☐ Yes ☐ No
Do you consent to coming to the office alone, having your temperature recorded and wearing a face covering or mask before entering the building and during the non-treatment portion of your visit.	☐ No ☐ Yes	☐ No ☐ Yes

I have filled out this questionnaire **COMPLETELY** and truthfully and to the best of my ability

Signature _____ Date _____