WOODBINE DENTAL

901 DeHirsch Ave Woodbine, NJ 08270
609-861-2784

COVID-19 Patient Screening Form

Patient Name DOB:	Before Appointment Date:	In-Office Appointment Date: Temperature:
Are you over 60 years of age?	Yes/No	Yes/No
Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	Yes/No	Yes/No
Are you experiencing shortness of breath or trouble breathing?	Yes/No	Yes/No
Do you have a temperature of 100.4 or higher?	Yes/No	Yes/No
Are you experiencing a sore throat?	Yes/No	Yes/No
Are you coughing?	Yes/No	Yes/No
Are you experiencing repeated shaking with chills?	Yes/No	Yes/No
Do you have muscle aches?	Yes/No	Yes/No
Are you experiencing gastrointestinal changes?	Yes/No	Yes/No
Have you noticed a loss of smell or taste?	Yes/No	Yes/No
Have you had contact with a known or suspected COVID-19 positive person?	Yes/No	Yes/No
In the last 14 days, have you traveled to an area that has a high incidence of COVID-19?	Yes/No	Yes/No

If yes to the question above, please specify: