Endodontic Group
885 Progress Ave. Suite 207
Scarborough, Ontario
M1H 3G3

T 416-438-7878
F 416-438-5524
info@endodonticgroup.com
www.endodonticgroup.com

Patient Screening Form for COVID-19

Patient Name: ____________________________________

	PRE-APPOINTMENT		**AT OFFICE**	
	Date: ___________		Date: ___________	
Have you tested positive for COVID-19 or are you awaiting results for a COVID-19 test?	☐ Yes	☐ No	☐ Yes	☐ No
Do you have any of the following: • Cold or flu-like symptoms • Fever • Cough • Sore throat	☐ Yes	☐ No	☐ Yes	☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes	☐ No	☐ Yes	☐ No
Have you experienced recent loss of taste or smell?	☐ Yes	☐ No	☐ Yes	☐ No
Even if you do not currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ Yes	☐ No	☐ Yes	☐ No
Are you, or have you in the last 14 days, in contact with any confirmed COVID-19 positive patients?	☐ Yes	☐ No	☐ Yes	☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes	☐ No	☐ Yes	☐ No
Temperature Check:	N/A		___________ ^{o}C	

If there is a positive response to any of these, we would recommend discussing with the dentist and team before proceeding with any elective dental treatment.