BITTNER DENTISTRY FOR KIDS PATIENT SCREENING FORM

Patient Name:	Date:
Has your child had a fever in the past 14 days?	☐ YES ☐ NO
Is your child having shortness of breath or other difficulties breathing?	☐ YES ☐ NO
Does your child have a cough?	☐ YES ☐ NO
Has your child had any flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐ YES ☐ NO
Has your child experienced recent loss of taste or smell?	☐ YES ☐ NO
Has your child been in contact with any confirmed COVID-19 positive patients?	☐ YES ☐ NO
Has your child traveled in the past 14 days?	☐ YES ☐ NO

I understand that there is an increased risk of Covid-19 and have been given the option of rescheduling this appointment.

Signature of Parent/Guardian _____