QUALITY CARE DENTAL LLP *300 S LITTLE TOR RD NEW CITY, NY 10956*
845-634-9155

COVID-19 Patient Screening Form

PRINT PATIENT NAME	**Before Appointment**
Are you over 60 years of age?	YES/NO
Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	YES/NO
Are you experiencing shortness of breath or trouble breathing?	YES/NO
Do you have a temperature of 100.4° F or higher?	YES/NO
Are you experiencing a sore throat?	YES/NO
Are you coughing?	YES/NO
Are you experiencing repeated shaking with chills?	YES/NO
Do you have muscle aches?	YES/NO
Are you experiencing gastrointestinal changes?	YES/NO
Have you noticed a loss of smell or taste?	YES/NO
Have you had contact with a known or suspected COVID-19-positive person?	YES/NO
In the last 14 days, have you traveled to an area that has a high incidence of COVID-19?	YES/NO
If yes to the question above, please specify:	

Please verify that all the information supplied above is correct by signing and dating this document

*X*_____