altura
PERIODONTICS
& DENTAL IMPLANTS
THE HEIGHT OF TREATMENT

Temperature :_____

Patient Screening Form

Patient Name:_____ Date:_____

IF YOU ANSWER "YES" TO QUESTIONS 1-9, YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.

1	Do you have a fever or have you felt hot or feverish recently (14-21 days)	☐ Yes ☐ No
2	Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No
3	Have you experienced recent loss of taste or smell?	☐ Yes ☐ No
4	Have you been 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
5	Do you have a cough?	☐ Yes ☐ No
6	Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No
7	Have you experienced any unexplained muscle pain?	☐ Yes ☐ No
8	Do you have a sore throat?	☐ Yes ☐ No
9	Do you have a runny nose?	☐ Yes ☐ No

If you answer "YES" to questions 10-12, please be advised you may be at an increased risk, however **we CAN still see you**. Please contact our office if you have any questions. 303-695-0990.

10	Is your age over 60?	☐ Yes ☐ No
11	Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No
12	Have you traveled in the past 14 days to any regions affected by COVID-19?	☐ Yes ☐ No

_____ _____

Patient Signature Date