Health Evaluation Form

Patient Name: ____

Do you have any of the following symptoms?

SYMPTOMS

Fever >38 C	☐ Yes	☐ No
New or worsening cough	☐ Yes	☐ No
Sore throat or painful swallowing	☐ Yes	☐ No
New or worsening shortness of breath	☐ Yes	☐ No
Difficulty breathing	☐ Yes	☐ No
Flu-like symptoms	☐ Yes	☐ No
Runny Nose	☐ Yes	☐ No

If you have any of the above symptoms, please phone our office prior to your dental appointment.

I verify the information I have provided on this form is truthful and accurate.

________________________________ ____________________________

Signature **Date**