MARY E. PEEBLES-TURNER, DDS, PC
899 Highway 287, Suite 600 • Broomfield, CO 80020 • (303) 460-9366 • www.broomfielddentist.com

Covid-19

Patient Screening Form

Patient Name: _____

	Pre Appt Date		In Office Date	
	YES	NO	YES	NO
Have you felt feverish in the past 14-21 days?				
Difficulties breathing, shortness of breath or cough?				
Any flu like symptoms?				
Any headache, fatigue, runny nose or nausea?				
Experience any recent loss of taste of smell?				
Any contact with anyone Covid positive?				
Have you traveled in the past 14 days?				

a.) If so where did you go? _____

b.) When did you get back? _____

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

Patient Signature	Date	Temperature