Waterford Endodontics

Practice Limited to Endodontics

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Pre-Appointment Patient Screening Form

Name	
Date	

Please answer the following:	Yes	No
Do you have a fever, cough, or difficulty breathing?	◯	◯
Do you have altered taste or sense of smell?	◯	◯
Have you been in contact with anyone diagnosed or suspected of having Covid-19?	◯	◯
Have you been abroad within the last two weeks? If so where? ----------	◯	◯
Do you have pre-existing heart, lung, kidney disease, diabetes or any auto-immune condition?	◯	◯
Are you 60 years of age or older?	◯	◯