COVID-19 Patient Screening

Our highest concern is the safety of your child and our dental team. To help keep you and our team safe, we ask that you fill out the following screening form prior to your visit.

1. Has your child or anyone in your household traveled internationally or domestically in the last 14 days? Yes or No

   If Yes, where? _____

2. Has your child or anyone in your household visited a long-term care nursing home facility in the last 14 days?
   Yes or No
3. Has your child or anyone in your household recently experienced a fever >100.4°?
   Yes or No

4. Has your child or anyone in your household recently tested positive for COVID (or awaiting testing results), experienced a cough, shortness of breath, diarrhea, loss of smell or taste, or any other flu-like symptoms?
   Yes or No
5. Has your child or anyone in your household been around any individual who has tested positive for COVID (or awaiting testing results) or has had any of the above symptoms in the last 14 days?
   Yes or No

I confirm these answers are accurate. I further understand that Dr. Chelsea Garcia cannot fully control, manage, or eliminate the risk of the spread of COVID-19 virus even with implementation of increased protective measures.

Patient names: _____

Parent Name: _____

Parent Signature: _____

Date: _____

To be completed by office staff
Temperature taken: _____ Initials: _____