ORAL & MAXILLOFACIAL SURGERY

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COVID 19 Questionnaire

Have you been out of the country within the last 14 days? ____Yes ____No

If Yes, where? _____

Have you been physically in close contact with someone within the last 14 days who has shown symptoms of COVID-19?

_____ Yes _____No

Have you had any of the following symptoms with the last 14 days?

*Coughing …… ____Yes ____No

*Shortness/difficulty breathing …… ____Yes ____No

*Fever ……. ____Yes ____No

If yes to any of the above, please contact your Primary Care Physician and todays appointment will need to be postponed. Thank you for understanding.

_____ _____
Patient's Name: Signature

_____ _____
Date: Patient ID #

Email: ctdentalimplantcenter@yahoo.com