South Hill Family Dental COVID-19 Screening Form

Please answer the following questions.

1. Do you have any of the following symptoms that are not caused by another condition?
    - Fever (greater than 100.3F)
    - Cough
    - Shortness of breath of difficulty breathing
    - Muscle or body aches
    - Recent loss of taste of smell
    - Sore throat
    - Congestion
    - Nausea or vomiting
    - Diarrhea
2. Within the past 14 days, have you had contact with anyone that you know had COVID-19 or COVID-like symptoms? Contact is being 6 feet or closer for more than 15 minutes with a person, or having direct contact with fluids from a person with COVID-19 (for ex. being coughed or sneezed on).
3. Have you had a positive COVID-19 test for active virus in the past 10 days?
4. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

If you answered yes to any of the following questions, we need to reschedule your appointment to a later date. Please call the office ASAP to change your appointment.