Supplemental Health Questionnaire

If you have been exposed to a communicable disease such as Covid-19, you may spread it to another patient or one of our team members. Therefore, we will be asking you the following questions before each visit.

Patient Name ____Date____________________
This form was filled out by: Patient / Parent / Other:___________________________________

Has the patient been in contact with anyone who has been confirmed Covid-19 positive?

	Yes	No

Does the patient have or recently had any of the following symptoms?

Fever (above 99.6* F)	Yes	No
Cough	Yes	No
Shortness of breath	Yes	No
Persistent pain, pressure or tightness in chest	Yes	No
Other flu like symptoms:		
-gastrointestinal upset, headache, fatigue	Yes	No
Loss of taste or smell	Yes	No

A "yes" response to any of the above questions will indicate a consultation with the doctor before proceeding, a potential delay of treatment and/or a possible referral for evaluation.

Patient Temperature:

Forehead____
Intra-oral (if elevated forehead) __________________________________

Wilson Orthodontics Team Signature ____