ATHENS DENTAL DEPOT

OFFICE USE ONLY:

Temperature: _____

Time: _____

Team Member: _____

Date: _____

Patient Name: _____ D.O.B: _____

Please answer the following questions to the best of your ability.

1. Have you traveled outside of the United States in the last 30 days? _____
2. Do you have flu-like symptoms such as, but not limited to: cough, fever, shortness of breath, runny nose, or sore throat? _____
3. Have you been in close contact with any confirmed COVID-19 patients or anyone experiencing flu-like symptoms? _____

Thank you for your patience and cooperation as we attempt to maintain the highest levels of infection control and safety.

Signature: _____