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Patient In-Office Screening Protocol

*** Take Patient Temperature Upon Arrival. Temperature: _____**

*** COVID-19 QUESTIONNAIRE:**

1. Have you tested positive for COVID-19?
Yes or No
2. Have you been tested for COVID-19?
Yes or No
3. Have you had any unexplained fevers in the past 21 days?
Yes or No
4. Do you have any of the following respiratory symptoms: Sore Throat, Cough, Shortness of Breath, Heaviness/Pressure in/around Chest Area, Wheezing?
Yes or No
5. Have you recently lost your sense of smell or taste?
Yes or No
6. Do you have any GI (Stomach/Bowel) symptoms, ex: Diarrhea, Nausea, Upset Stomach?
Yes or No
7. Even if you don't have these symptoms now, have you experienced any of these symptoms in the last 21 days?
Yes or No
8. Have you been in contact with anyone who has tested positive for COVID-19 in the last 21 days?
Yes or No
9. Have you traveled outside of the United States by air or cruise ship in the past 21 days or been in contact with anyone who has?
Yes or No
10. Have you traveled inside of the United States by air, bus, or train within the past 21 days or been in contact with anyone who has?
Yes or No
11. Have you been to any of the high ranking pandemic states or been in contact with anyone who has in the past 21 days?
Yes or No

PATIENT NAME	PATIENT SIGNATURE	DATE