Patient Name: Patient DOB:

Please fill out form and return to front desk staff immediately:

☐ Have you previously been screened and found to be at risk for Covid-19 and/or required testing? If screened, were you found to be positive?

☐ Do you currently have a fever and/or respiratory symptoms including cough and shortness of breath? YES / NO

☐ Have you been in close contact with someone who has tested positive for Coronavirus or is suspected of coronavirus and has been quarantined and currently awaiting results? YES / NO

☐ Have you personally traveled out of town within the past 14 days? YES / NO If yes, Travel Location?

☐ Have you been in close contact with someone in your household or workplace with whom you frequently interact and who is known to have travelled in the past 14 days? YES / NO If yes, Travel Location?

☐ NONE of these above apply to me