E Dental
Paul F. Eckstein, DMD

Covid 19 Questionnaire

Have you had any of the following symptoms in the last 14 days? (Check all that apply)

- ☐ Fever
- ☐ Cough
- ☐ Colds, Chills
- ☐ Headache
- ☐ Sore Throat
- ☐ Diarrhea
- ☐ Shortness of Breath
- ☐ Joint pain or body aches

Have You?

- ☐ Traveled to any foreign countries in the last 14 days?
- ☐ Traveled by airplane in the last 14 days?
- ☐ Been in contact with a person known to have tested positive for the Covid 19 Virus?
- ☐ Had exposure to a person under investigation (PUI) for Covid 19?
- ☐ Had a test for Covid 19 or had an antibody test for Covid 19? IF yes please explain:

_____

- ☐ I certify that the above are true to the best of my knowledge and that if any of these answers change during my treatment with E Dental that I will notify the office immediately.

Temperature Recorded: _____ Date: _____ Initials: _____

Signed: _____ Printed Name: _____ Date: _____

Signature of Office Personnel: _____ Name: _____