PATIENT COVID-19 SCREENING FORM-OFFICE

COVID Test Date:_____ **Time:**_____

Patient Name:_____**Gender:** ◯ Male ◯ Female ◯ Other

Date of Birth:_____ **Email Address:**_____**Phone#:**_____

Address:_____ **City:**_____**Zip:**_____

Insurance:_____ **ID#**_____

Guarantor:_____ **Date of Birth:**_____

Local Pharmacy_____**Cross Streets**_____

DATE:_____

Please check all the symptoms that apply

☐ Cough (New onset or worsening of chronic cough)

☐ Fever, 100.4 or greater

☐ New onset sore throat

☐ New onset nasal congestion sneezing or runny nose (not related to chronic condition/allergies).

☐ You have been exposed to the COVID virus in the last 10 days

☐ You have tested positive for COVID in t the last 5 days?

- Have you received the COVID Vaccine? ◯ **Yes** ◯ **No**

- **If patient has any two of the symptoms checked above, or has been exposed in the last 10 days or tested positive in the last 5 days, offer a telehealth visit at home or to be seen in their car if questions check with provider.**
- **If no symptoms, exposure or positive test please register patient or offer telehealth visit if patient would like one or if we are very busy.**

PRE-OP COVID Testing

SURGEON: First Name_____Last Name_____

Procedure Date_____Fax#_____

Exposure: ◯ Yes ◯ No **Date:** _____

Symptoms: ◯ Yes ◯ No **Onset Date:**_____

ALL PATIENTS IN THE OFFICE MUST WEAR A MASK AT ALL TIMES.

Intake by: _____