Patient Information

(Confidential)

Dale D. Batten, DMD, PA
Comprehensive Dentistry

Name _____ Date _____
First Last

Address _____

City: _____ State _____ Zip _____

Email: _____

Cell Phone ( ) _____ Home Phone ( ) _____ Work Phone: ( ) _____

Preferred method of contact: Text Cell Home Email Other

COVID 19 Patient Screening Form:

		Pre-Appointment Date: _____		In Office Date: _____	
		YES	NO	YES	NO
1.	Do you have or had a fever or felt feverish in the last 14 to 21 days?	☐	☐	☐	☐
2.	Are you having shortness of breath or difficulty breath?	☐	☐	☐	☐
3.	Do you have a cough?	☐	☐	☐	☐
4.	Do you have any flu like symptoms such as gastrointestinal upset, headaches or fatigue?	☐	☐	☐	☐
5	Have been in contact with any confirmed COVID 19 patients?	☐	☐	☐	☐
6.	Have you traveled in the last 14 days. Where?	☐	☐	☐	☐
7.	Temperature:				

New Patients Only

8.	Do have any history of heart, lung, kidney disease, Diabetes or any auto-immune disorders.	☐	☐	☐	☐
9.	Are you over the age of 60?	☐	☐	☐	☐

Provider _____ Appt Date / Time _____

COVID 19 Release on reverse side