LorenzanaPeriodontics

PERIODONTICS • ORAL PLASTIC SURGERY • DENTAL IMPLANT AESTHETICS

COVID-19 Screening Form

Name: _____ Date: _____ Time: _____

Phone: _____ Email: _____

□ Patient □ Family/Guardian/Friend of Patient Name: _____

1. Have you tested positive for COVID-19? □ YES □ NO
2. Have you been tested for COVID-19 and are awaiting results? □ YES (when _____) □ NO
3. Do you have any of the following respiratory symptoms? Fever, sore throat, cough, shortness of breath? □ YES (If Yes, which: _____) □ NO
4. Have you recently lost your sense of smell or taste? □ YES □ NO
5. Do you have any GI symptoms? Diarrhea? Nausea? □ YES □ NO
6. Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? □ YES (If Yes, which: _____) □ NO
7. Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days? □ YES □ NO
8. Have you traveled outside the United States by air or cruise ship in the past 14 days? □ YES □ NO
9. Have you traveled within the United States by air, bus or train within the past 14 days? □ YES □ NO

If you answered YES to any of the above questions, please call the office at (210) 492-3519 or Dr. Lorenzana on his personal cell phone at (210) 744-4867 to discuss immediately.

Otherwise, please download and print out this form. Please bring with you to your appointment.

Thank you!

Dr. Lorenzana

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