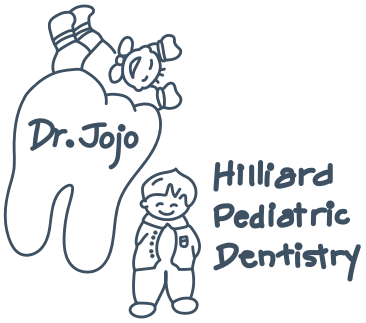

Jojo Montero Strickler, D.D.S.
Pediatric Dentist

COVID-19 SCREENING FORM

Patient's Name _____ Date of Birth:_____

Is your child:	
Under the care of a physician? If yes why:_____	☐YES ☐NO
Any recent surgeries, hospitalizations, emergency room vists? If yes when:_____	☐YES ☐NO
Any medications? If yes what:_____	☐YES ☐NO
Any allergies? If yes what:_____	☐YES ☐NO
Does your child have:	
Fever/feel hot in the past (14-21 days)?	☐YES ☐NO
Shortness of breath/breathing difficulties?	☐YES ☐NO
Cough?	☐YES ☐NO
Flu-like symptoms, headache, fatigue, stomach upset?	☐YES ☐NO
Recent loss of taste or smell?	☐YES ☐NO
Heart/lung/kidney disease, diabetes or auto-immune disorders?	☐YES ☐NO
Traveled in the past 14 days to any regions affected by Covid-19?	☐YES ☐NO
Been in contact with any confirmed Covid-19 positive patients? (Patients who are well but who have a sick family member at home with COVID-19 should consider rescheduling treatment.)	☐YES ☐NO
Any insurance/address/telephone changes?	
Parent/guardian email:	
✱(Staff will fill this section out) Patient Temperature:	

Thank you for your cooperation & your patience as we continue to follow CDC guidelines.
Upon your entry, we will be recording your child's temperature.
Welcome back! Dr. Jojo & Staff

614-876-5500

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