John P. Ritota, D.D.S
Theodore C. Ritota, D.M.D
Delray Dental Building
3401 South Federal Highway
Delray Beach, FL 33483
(561) 272-6664
www.delraydental.com

Patient Screening Form for COVID-19

Name: _____

Date: _____

	Before Appointment	At Office
	Date: _____	Date: _____
Do you/they have fever or have you/they felt hot or feverish recently (past 14-21 days)?	▢ Yes ▢ No	▢ Yes ▢ No
Are you having shortness of breath or other difficulties breathing?	▢ Yes ▢ No	▢ Yes ▢ No
Do you/they have a cough?	▢ Yes ▢ No	▢ Yes ▢ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	▢ Yes ▢ No	▢ Yes ▢ No
Have you/they experienced recent loss of taste or smell?	▢ Yes ▢ No	▢ Yes ▢ No
Are you/they 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 postponing elective treatment.*	▢ Yes ▢ No	▢ Yes ▢ No
Is your/their age over 60?	▢ Yes ▢ No	▢ Yes ▢ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	▢ Yes ▢ No	▢ Yes ▢ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	▢ Yes ▢ No	▢ Yes ▢ No
Are you allergic to Iodine?	▢ Yes ▢ No	

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

John P. Ritota D.D.S
Theodore C. Ritota, D.M.D
3401 South Federal Highway
Delray Beach, FL 33483
(561) 272 – 6664
www.delraydental.com

Established Patient – Dental and Medical History Update

Patient Name:_____ Date of Birth: _____

Contact Information

- Email Address: _____
- Mailing Address: _____
- Phone Number: _____

		IF YES, PLEASE EXPLAIN:
Do you have new dental insurance?	**YES NO**	
Any changes in your dental health since your last visit?	**YES NO**	
Any changes in your medical history since your last visit?	**YES NO**	
Any surgeries/hospitalizations since your last visit?	**YES NO**	
Are you taking any medications? (Prescription and Non-Prescription)	**YES NO**	
Are you allergic to any medications, latex, or iodine?	**YES NO**	
***FEMALES ONLY:* Are you pregnant?**	**YES NO**	

I certify that I have read, and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Patient Signature **Date**