ANDREW WHEATLEY, DDS
AT TECUMSEH RIDGE DENTAL

COVID-19 Patient Questionnaire

Name: _____ Birthday: _____
Phone number: _____
Address: _____
E-Mail: _____
Are we going to be filing insurance for you?
Insurance company: _____
insurance ID#_____
insurance company phone # on back of card_____
Are you in pain? **YES / NO**
On a scale of 1 to 10 (one being no pain and 10 being the worst pain you can imagine), what's
your pain level? _____
The CDC recommends health care facilities, including dental offices, evaluate patients before they arrive
for their appointment to screen for anyone who may be ill with, or who has been exposed to, the new
coronavirus (COVID-19).
1) Have you or anyone close to you experienced a fever within the past 14 days? **YES / NO**
2) Have you or anyone close to you experienced flu-like symptoms within the past 14 days such
as:
- Cough – wet or dry **YES / NO**
- Fever **YES / NO**
- Shortness of Breath **YES / NO**
- Sore Throat **YES / NO**
- Muscle/Body Aches **YES / NO**
- Difficulty Breathing **YES / NO**
- Fatigue **YES / NO**
- A recent lack of taste or smell **YES / NO**

3) Have you come into contact with anyone who has tested positive for COVID-19? **YES / NO**
4) Have you been tested for Covid-19, with either a positive or negative result? **YES / NO**
5) Have you been fully vaccinated for Covid-19? **YES/NO**

To assure the health and safety of all our patients and employees, please consent to a screening for
COVID-19 symptoms prior to your treatment.

I, _____, consent to a screening prior to treatment.
I,_____, consent to treatment by Dr. Wheatley, DDS and his Team.
I,_____, certify that all the above answers are true.

_____ _____
Patient or guardian signature Date

_____ _____
DDS Signature Date