Colombo Dental Associates
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(516) 799-1787

COVID-19 PATIENT SCREENING FORM

Name_____ Date_____

1. Do you have a fever or have you felt hot? Yes No
2. Do you have shortness of breath or other difficulties breathing? Yes No
3. Do you have a cough? Yes No
4. Any other flu-like symptoms? Yes No
5. Have you experienced a recent loss of taste or smell? Yes No
6. Have you traveled in the past 14 days out of the USA? Yes No

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Signature