Required Screening Questions

Name: _____

Address: _____

Phone Number: _____

Mark / fill in the box next to each question if YES.
Leave blank for NO. ☐

☐ **Do you have any of the following new or worsening symptoms or signs? Symptoms should not be chronic or related to other known causes or conditions.**

- Fever or chills
- Difficulty breathing or shortness of breath
- Dry cough
- Decrease or loss of smell or taste
- Runny nose/stuffy nose or nasal congestion
- Nausea, vomiting, diarrhea, abdominal pain
- Not feeling well, extreme tiredness, sore muscles
- Medically compromised

☐ **Have you travelled outside of Ontario or Canada in the past 14 days?**

☐ **Have you had close contact with a confirmed or probable case of COVID-19?**

NEW hamburg DENTAL GROUP