



River City Dentistry, PC (Jason Allred, DMD)

rivercitydentistry.com

737 N.Thornton St. Suite #A • Post Falls, ID 83854

rivercityoffice@gmail.com

(208)777-8668

Patient Name: _____
Last First MI Preferred Name

Do you have a fever or felt hot/feverish within the last 14-21 days? Yes No

Check temperature: _____

Do you have shortness of breath or difficulties breathing? Yes No

Do you have a cough? Yes No

Is cough related to allergies, medication, or smoking? _____

Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue? Yes No

If answered yes to above, please specify _____

Have you experienced recent loss of taste or smell? Yes No

Are you in contact with any confirmed COVID-19 positive patients?
(Patients who are well but who have sick family members at home with COVID-19 should consider postponing elective treatment)
 Yes No

Are you over 60 years old? Yes No

Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorder? Yes No

If answered yes to above, please specify _____

Have you traveled in the past 14 days to any regions affected by COVID-19? Yes No

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

Response Date: _____