Covid 19 Screening Form

Name _____

Address _____

Date of Birth ___ /___ /___

Please circle your answer

Have you recently travelled to a high-risk area?	Yes/No
Have you had any contact with a confirmed case of Covid-19 or anyone displaying symptoms of Covid-19?	Yes/No
Have you experienced any difficulty breathing, shortness of breath, or increased mucus production in the last 14 days?	Yes/No
Have you experienced a cough (dry or chesty)	Yes/No
Have you noticed yourself to be either hot or cold which is not in keeping with your environment?	Yes/No
Have you experienced any flu-like symptoms?	Yes/No
Have you or anyone in your household been advised to self-isolate in the last 14 days?	Yes/No
Are you awaiting screening for Covid-19?	Yes/No

Patient temperature on entry to surgery _____

Patient signature _____

Staff signature _____

Macroom Dental Surgery, Middle Square, Macroom, Co. Cork.
Tel: 026 – 41052
CONFIDENTIAL

Patient's Name: _____Date of Birth: _____ Sex: M / F

Address: _____

_____E-mail: _____

Contact Number: Home: _____Mobile: _____

P.P.S. Number: _____Health Insurance: Yes / No

Medical Card Number: _____ Valid to: _____

Yes / No

1. Are you taking any medicines, tablets or capsules at present? .....____/_____
If so, **please name them**.
.....

2. **Do you have a cough, shortness of breath, difficulty breathing or felt feverish in the last 2 weeks_____/_____**

3. **Have you any flu like symptoms or been in contact with anyone / facility associated with COVID-19 Yes / NO**

4. Are you currently or have you recently received steroid treatment? .....____/_____

5. Are you allergic to penicillin? .....____/_____

6. Have you ever had any unusual response to any drug or medicine?**Please name** .....____/_____

7. Have you ever had Rheumatic fever? .....____/_____

8. Have you ever had a Heart Murmur/Congenital Heart defect/Heart Attack? .....____/_____

9. Have you ever had a Joint / Valve Replacement? .....____/_____

10. Do you have a Pacemaker or have you ever had heart surgery.....____/_____

11. Do you suffer from high blood pressure? .....____/_____

12. Do you suffer from Hay Fever, Asthma or any Allergies? **Please circle** .....____/_____

13. Do you suffer from Epilepsy, fainting attacks or black – outs? **Please circle**.....____/_____

14. Do you suffer from Diabetes? .....____/_____

15. Have you ever had Radiotherapy or Chemotherapy? .....____/_____

16. Have you ever suffered from Hepatitis, Jaundice or Liver Disease? **Please circle.....**____/_____

17. Do you suffer from HIV infection? .....____/_____

18. Have you had excessive bleeding after extractions? .....____/_____

19. Are you pregnant? .....____/_____
Have previous dental extractions been difficult? .....____/_____

21. Is there any medical condition not mentioned that you would like to discuss in confidence with your dentist? .....____/_____

22. Are you happy to be contacted by text message/e–mail if necessary?.....____/_____

23. I have read the ***"Practice Privacy Statement"*** for **Macroom Dental Practice** and understand that my data will be used only for my treatment. **Please circle either**.....***YES / NO***.

24. ***Department of Social Protection – Treatment Benefit consent:***

25. I consent to the use of necessary dental X-rays required for my treatment.....____/_____

I the undersigned, authorise **Macroom Dental Practice** to use my personal data for the purposes of checking my eligibility for Treatment Benefits and to allow for the processing of the payment claim in respect of treatments I have received.

Patient's Signature (or Parent/Guardian): _____Date: _____

Signature on behalf of Macroom Dental Practice: _____

Your Doctor's Name & Address: _____