Stafford
ORAL SURGERY
& SPECIALISTS

COVID-19 Visitor Screening

To protect our patients and team, and in accordance with state guidelines, we are screening visitors to our office. Please complete the following questions.

1. I have received a vaccination for COVID-19: (optional) Yes No
2. I currently have symptoms related to COVID-19: Yes No
3. I have had symptoms related to COVID-19 within the past 14 days. Yes No
4. I currently have a fever: Yes No
5. Within the past 14 days, I have been in known contact with an individual with COVID-19: Yes No
6. Within the past 14 days, I have had prolonged contact with someone who has cold/flu symptoms: Yes No

THANK YOU FOR PROVIDING US WITH THIS INFORMATION, WE SEEK TO KEEP OUR PATIENTS AND STAFF AS SAFE AS POSSIBLE AS WE CONTINUE TO RECOVER FROM THIS PANDEMIC.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____