Ridge Family Dental: Wellness Form

We are aware and understand the concerns and worry about COVID-19. We want to assure you that the health, well-being, and safety of all of our patients and team members, as always, our top priority.
We are kindly asking our patients to assist us in reducing the risk of exposure.

Please answer the following questions provided by CDC Guidelines.

First Name:

Last Name:

Phone:

Email:

1.Do you or have you had any flu-like symptoms in the last 14 days, such as fatigue, headache, or gastrointestinal upset? Yes / No

2. Do you have a cough? Yes/No

3. Do you have a fever now or have you in the last 14-21 days? Yes/No

4. Are you experiencing shortness of breath or difficulty breathing? Yes/No

5. Are you awaiting results of a lab test for COVID-19? Yes / No

6. Have you tested positive for COVID-19? When? Yes / No

7.Have you or a family member previously been asked to self-quarantine in the past 14 days? Yes / No

8.Have you had close contact to an individual diagnosed with COVID-19 in the past 14 days? Yes / No

9.Have you travelled to any region affected by COVID-19 in the last 14 days? Yes / No

10.Have you received the COVID-19 vaccine? When? Yes/No