Screening / Triage Intake Form

Initial Call Date:			**Description of Chief Complaint:**
Patient Name:			
DOB:			
Phone Number:			
Dental Insurance:			

Circle the Answer:				
Pain Present:	Yes -or- No			
Pain Level:	1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10			
Duration of Pain:	_____ : hours / days / weeks			
Bleeding:	Yes -or- No			
Swelling:	Yes -or- No		**Emergency Appt Needed:**	Yes -or- No
Does OTC pain medicine help?:	Yes -or- No		**Appt Date:**	

Screening Questions		**Initial Call**	**Check-In**	**Treatment Area**
1	Have you had a fever of 100.0° or higher, cough or shortness of breath in the last 14 days?			
2	Have you travelled outside the area in the last 14 days?			
3	Have you or a family member been exposed to COVID-19?			
4	Have you or your family members tested positive for COVID-19?			
5	If Yes to #4, Have you been cleared from Quarantine by your PCP? (Please provide a medical clearance form)			

Patient's Temperature:	_________ ° Degrees Farenheit

Clinical notes to be documented in the patient's chart:

Todays Completed / Billable Treatment:

Next Visit Proposed / Treatment Coordination Needs: