OMNIA DENTAL SPA
cosmetic dentistry & facial rejuvenation clinic

OMNIA -COVID-19 – PATIENT SCREENING QUESTIONNAIRE

In order to ensure that we can treat you safely, you MUST print this form and answer the 7 questions below accurately. Your answers will allow us to assess your level of risk for Coronavirus. This information is essential in order to protect you, other patients, our dental team and the wider community.

Please note that we will also call you, before your appointment, to ask you these 7 questions verbally over the telephone.

Please bring this completed **Screening Form**, along with your updated **Medical History Form**, with you when you attend for your booked appointment. Please be advised that we will NOT be able to assess or treat you unless BOTH forms are **completed, signed** and **dated.**

Your Name: ________________________ **Date of Birth:** __________________

(Please circle)

1. Have you, or anyone in your household, tested positive for COVID-19 in the last 7 days? **NO or YES**
2. Are you waiting for a COVID-19 test or the results of a test? **NO or YES**
3. Do you have any of the following symptoms?
   - A new, continuous cough? **NO or YES**
   - A high temperature or fever (37.8°C or over)? **NO or YES**
   - A loss of, or change in, your normal sense of smell or taste? **NO or YES**
4. Do you live with someone who has either tested positive for COVID-19 or had symptoms of COVID-19 in the last 14 days? **NO or YES**
5. In the last 14 days, have you been notified by NHS Test and Trace that you are a contact of a person who has tested positive for COVID-19? **NO or YES**
6. Do you fall into the '**clinically vulnerable**' group? (over 70 years of age or under 70 years with an underlying chronic health condition e.g. anyone instructed to get a flu jab each year on medical grounds) **NO or YES**
7. Have you received a letter from your doctor advising you to '**shield**' yourself during the current Coronavirus pandemic? **NO or YES**

PLEASE SIGN: ________________________ **DATE:** ____________________