

Whyman House Dental Practice –Patient COVID-19 Risk Assessment

Please Answer the Following 6 Questions.

Question 1	Question 2	Question 3
Have you tested positive for COVID 19 in the last 7 days?	Are you waiting for a COVID-19 test or the results of a test?	Do you have any of the following symptoms: New Continuous cough? High temperature or fever? Loss of, or change in sense of smell or taste?
YES / NO	YES / NO	YES / NO
Question 4	Question 5	Question 6
Do you live with someone who has either tested positive for COVID-19 or Had symptoms of COVID-19 in the last 14 days?	Have you been notified by NHS Test and Trace in the last 14 days to say that you are a contact of someone who has tested positive for COVID-19? and You don't live with that person?	Are you currently in a 14 day self-isolation or quarantine period following foreign travel?
YES / NO	YES / NO	YES / NO

If you have answered 'YES' to any of these questions, please contact the Practice ASAP

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

If there has been any significant change to your medical history, you will need to complete a new Medical History form. This form can be found at www.whymanhousedental.com