NorthCreekDentalCare
Don Koontz, DDS

Wellness Form

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Have you been vaccinated for COVID19?

Yes ☐ No ☐

Have you traveled within or outside of the United States in the last 14 days?

Yes ☐ No ☐ Where: _____

Have you come into contact with anyone who has tested positive or who is waiting for test results for COVID19 in the last 14 days?

Yes ☐ No ☐

Are you experiencing any of the following symptoms in the last 14 days:

Had a fever?	Yes ☐	No ☐
Cough or sore throat?	Yes ☐	No ☐
Shortness of breath / Difficulty breathing?	Yes ☐	No ☐
Recent loss of taste or smell?	Yes ☐	No ☐
Other flu like symptoms (gastrointestinal upset, headache, or fatigue)	Yes ☐	No ☐

Do you have heart disease, lung disease, or any auto-immune disorder?
Yes ☐ No ☐

Are you over the age of 60?

Yes ☐ No ☐

If you answered yes to any of the above questions, please explain:

_____

_____

Signature: _____ Date: _____