kb dental
KRISTEN BALUTOWICZ DDS

Patient Screening Form

Patient Name: _____

Please take a few moments to answer the following questions. These will help us make sure we are providing the safest and best care for our patients.

	Yes	No
Have you had a fever or felt hot / feverish over the last 2-3 weeks?		
Are you having any shortness of breath or any difficulties breathing?		
Do you have a cough?		
Any other flu-like symptoms, such as an upset stomach, headache, or extreme fatigue?		
Have you experienced any recent loss of taste or smell over the last 2-3 weeks?		
Are you in contact or have you been in contact with any COVID-19 positive patients?		
Do you have any heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?		
Have you traveled recently? If so, where? _____		

If you have answered yes to any of the following questions, please call us prior to arriving at our office at 248.879.7240 and let us know. **If you would like to speed up the check-in process, email this completed form to info@kbdentaltroy.com one day prior to your visit.**

I have read and understand the above questions and have answered them to the best of my ability. In addition, with my signature, I am reconfirming my desire to have a dental procedure performed today.

Signature:_____ Date:_____

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