Covid-19 Risk Assessment **Form**

ENDO MISHRA
The root canal specialist

This is a downloadable COVID-19 screening form for dental patients
This patient questionnaire must be filled in within 24 hours of appointment and emailed to us at info@endomishra.co.uk

Title | Last name | First name

Sex | Preferred Name | DOB

Address | Post Code

Home Phone | Mobile

Occupation | Email

In the event of an emergency, please contact

Name | Phone | Relationship to you

Doctor's details

Doctor's Name | Post Code

Address

All details are strictly confidential

	Yes	No		Yes	No
Have you travelled by public transport today?	☐	☐	Loss of taste and/or smell	☐	☐
Have you recently developed any of the following symptoms?	☐	☐	Headaches	☐	☐
Persistent cough	☐	☐	Itchy eyes	☐	☐
High temperature	☐	☐	Diarrhoea	☐	☐
Shortness of breath	☐	☐			

If 'YES' to any of these questions please supply details and inform and member of staff

Disclaimer

Completed by: Self ☐ Parent ☐ Guardian ☐ Other - Please state

Patient Signature

Date

For practice use only: **Comments of risk**

Staff Initial

Date

Correspondence Address

EndoMishra Ltd
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Baldock, Hertfordshire SG7 6AZ

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