2810-115 Wakefield Pines Dr.
Raleigh, NC 27614

Wake Dental Sleep
General Dentistry and Sleep Oral Appliance Therapy
Jennifer Q. Le. DMD, D-ABDSM, CPCC

Voice: (919) 488-0111
Fax: (919) 488-0104

Patient Name:___________________________________

	PRE-APPOINTMENT		IN-OFFICE	
	Date:		Date:	
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes	No	Yes	No
Are you/they having shortness of breath or other difficulties breathing?	Yes	No	Yes	No
Do you/they have a cough?	Yes	No	Yes	No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes	No	Yes	No
Have you/they experienced recent loss of taste or smell?	Yes	No	Yes	No
Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID -19 should consider postponing elective treatment.	Yes	No	Yes	No
Is your/their age over 60?	Yes	No	Yes	No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes	No	Yes	No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes	No	Yes	No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

• For testing, see the list of State and Territorial Health Department Websites for your specific area's information

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