Dr. Massimo V. Verduci
Hometown Orthodontic Care

COVID-19 Screening Form

First & Last Name: _____ **Date:** _____

(1) Have you been exposed to or tested positive for Covid-19 in the past 10 days? ☐ **YES** ☐ **NO**

*If you answered YES to (1), what was the date of Covid-19 exposure or positive test result?

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Have you had any of the following symptoms in the past 10 days?

Fever or chills	☐ **YES**	☐ **NO**
Shortness of breath, breathing difficulties, sore throat or cough	☐ **YES**	☐ **NO**
Congestion or runny nose (unrelated to seasonal allergies)	☐ **YES**	☐ **NO**
Loss of taste or smell	☐ **YES**	☐ **NO**
Nausea, vomiting or diarrhea	☐ **YES**	☐ **NO**
Unusual headaches, fatigue or muscle/body aches	☐ **YES**	☐ **NO**

In the past 10 days, have you travelled outside of the United States to a foreign country? If YES, where? ☐ **YES** ☐ **NO**

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Please call the office (609-689-9292) from your car to inform us of your arrival.