



1. Are you having any of the following symptoms? Check all that apply.

- Fever (100.4 or above)
- Cough
- Shortness of Breath
- No Symptoms

2. Have you been in contact with a confirmed COVID-19 person in the last 14 days? Check one.

- Yes No

3. Have you traveled outside of the state of Tennessee in the last 14 days? Check one.

- Yes No

*If yes, please indicate where you traveled (city, state, country): _____

Name:
Date of Birth:
Cell Phone:
Are you a PATIENT OR A VISITOR?

<i>For Office Use Only</i>	
Patients	If response is "Yes" to 1 or 2, please reschedule appointment for the patient.
	If response is "Yes" to 3 and travel area is a high COVID-19 concentration, please reschedule appointment for patient.
Visitors	If response is "Yes" to any of the above questions, visitor cannot proceed.
Staff Signature:	Date: