THE CENTER FOR COSMETIC SURGERY & medi Spa

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Name:_____ Date:_____

Modified COVID19 Patient Screening Questionnaire to confirm your Appointment

Dear Patient,

In the interest of **SAFETY FIRST**, Team Kane continues to follow COVID-19 precautions.
We require that you complete the COVID-19 screening questionnaire below prior to each office visit.
We must receive it within the next 24 hours to confirm your appointment.
Without this completed form, your appointment will be canceled.

Including today and during the past 14 days, I have *NOT* had symptoms of COVID19 / COLD / FLU including but not limited to **FEVER** over 100.0 F without Tylenol, and wet or dry **COUGH**, **SNEEZING** or **RUNNY NOSE.**

_____ _____
Patient Signature Date

We require employees and patients to wear a proper mask covering your nose and mouth during your visit.

Thank you!