Please print and fill out pre-appointment section the day before your appointment.

If you answered yes to anyone of the questions. Please let us know.

Office Use Only:
Temp:
1st reading: _____ °F
2nd reading: _____ °F
3rd reading: _____ °F
Method:
☐ Oral
☐ Forehead scan
☐ Wrist scan

One questionnaire per person, please.

➢ **Masks must be worn by all who enter our office.**

TMJ Arizona
Rebecca L. Griffiths, B.S., D.M.D.
3420 East Shea Blvd Suite 151
Phoenix, AZ 85028
602-867-4317

☐ Patient: _____

OR

☐ Visitor name: _____

Fill out this portion the day before your appointment. >>>>>>>	Pre-screening	Answer In Office
>>>>>>>>>>>>>>	Date:	Date:
1. Do you/they have a fever or have felt hot or feverish in the last 2 to 3 weeks?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you/they having shortness of breath of difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
4. Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
6. Are you/they in contact with any confirmed COVID-19 positive patients, either at home or work?	☐ Yes ☐ No	☐ Yes ☐ No
7. Is yours or their age over 60? (This question is only necessary for informing you of the possible risk of being in public)	☐ Yes ☐ No	☐ Yes ☐ No
8. Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No

➢ Any yes answers will indicate a need to postpone elective treatment or further discussion with Dr. Griffiths.

Signature and date will be requested at the time of visit.

_____ _____

Patient, visitor or responsible party signature Date

_____

Rebecca L. Griffiths, B.S., D.M.D.

➢ **Masks must be worn by all who enter our office.**

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