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

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

One person per questionnaire, please.

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

TMJ Arizona
Rebecca L. Griffiths, B.S., D.M.D.
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Phoenix, AZ 85028
602 -867 -4317

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

Patient: _____

OR are you a visitor:

Visitor name: _____

Fill out this portion the day before your appointment. >>>>>>>	**Pre-screening**	Complete 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
9. Have you had any of the COVID Vaccines? If so, which version? _____	☐ Yes ☐ No	☐ Yes ☐ No

➢ Any yes answers may 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.

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