premierdentistry
TEL: 300-3221/3222 • PREMIERDENTISTRYGUAM.COM
692 N. MARINE CORPS DR. STE 301 UPPER TUMON, GU 96913

Patient COVID-19 Screening Form

Patient Name: _____

Call Confirmation Date: _____ **In-Clinic Screening Date:** _____

1. Have you had a fever within the past 14 days?	
2. Have you had shortness of breath or difficulty breathing?	
3. Have you been coughing?	
4. Have you lost your sense of smell or taste recently?	
5. Have you experienced any flu-like symptoms (gastro-intestinal problems, headaches, fatigue)?	
6. Have you been in contact with a confirmed COVID-19 case?	
7. Do you have heart disease, lung disease or diabetes?	
8. Are you over 60 years old?	

1. Current temperature:	
2. Are you experiencing trouble breathing?	
3. Have you been coughing?	
4. Have you lost your sense of smell or taste?	
5. Are you experiencing any flu-like symptoms (gastro-intestinal problems, headaches, fatigue)?	
6. Have you been in contact with a confirmed COVID-19 case?	
7. Do you have heart disease, lung disease or diabetes?	
8. Are you over 60 years old?	

Caller: _____ **Screener:** _____

CALLER NOTE: For all NON-URGENT (elective) procedures, if any answers are YES (except question 8), please re-schedule the patient for another time. For URGENT CARE patients, please notify them that they will undergo additional screening on the day of the appointment, and if they have a fever, they will have to be re-scheduled.

SCREENER NOTE: For all NON-URGENT (elective) procedures, if any answer is YES, **and** the current in-clinic temperature reading is > 100.4°F, please re-schedule the patient for another time. For URGENT CARE patients, please flag this form to notify back clinic staff that the patient is high-risk.