Michelle M. Espinoza, DDS

Restorative and Family Dentistry info@baybreezedental.net www.baybreezedental.net (858) 272-5550

Covid Patient Screening Form

Patient Name:

Date			Date			Date		
Do you have Covid?	Yes	No	Do you have Covid?	Yes	No	Do you have Covid?	Yes	No :
Have you been told to quarantine do due Covid?	Yes	No	Have you been told to quarantine do due Covid?	Yes	No	Have you been told to quarantine do due Covid?	Yes	No
Do you have Covid symptoms?	Yes	No	Do you have Covid symptoms?	Yes	No	Do you have Covid symptoms?	Yes	No
Temp:		8	Temp:			Temp:		

Date		V2	Date	1	30000	Date		
Do you have Covid?	Yes	No	Do you have Covid?	Yes	No	Do you have Covid?	Yes	No
Have you been told to quarantine do due Covid?	Yes	No	Have you been told to quarantine do due Covid?	Yes	No	Have you been told to quarantine do due Covid?	Yes	No
Do you have Covid symptoms?	Yes	No	Do you have Covid symptoms?	Yes	No	Do you have Covid symptoms?	Yes	No
Temp:			Temp:	5-		Temp:		

		(- '					
Date			Date			Date		
Do you have Covid?	Yes	No	Do you have Covid?	Yes	No	Do you have Covid?	Yes	No
Have you been			Have you been			Have you been		
told to quarantine do due Covid?	Yes	No	told to quarantine do due Covid?	Yes	No	told to quarantine do due Covid?	Yes	No
Do you have			Do you have	9.8		Do you have		3.
Covid	Yes	No	Covid	Yes	No	C ovid	Yes	No
symptoms?			symptoms?	*		symptoms?	•	
Temp:			Temp:			Temp:		