Bay Breeze DENTAL

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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:		Temp:		Temp:	

Date		Date		Date	
Do you have Covid?	Yes No	Do you have Covid?	Yes No	Do you have Covid?	Yes No
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