COVID-19 Pandemic Patient Consent Form

Patient name:___________________________________

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. ______ (Initial)

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office. _____(Initial)

I confirm that I am not presenting any of the following symptoms of COVOID-19 identified by **Provincial** Health Services:

· Fever > 38°C ____(Initial)
· Cough ____(Initial)
· Sore Throat ____(Initial)
· Shortness of Breath ____(Initial)
· Flu-like symptoms _____(Initial)
I confirm that I am not currently positive for the novel coronavirus. ____(Initial)

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus.
______(Initial)
I verify that I have not returned to **Provincial** from any country outside of Canada whether by car, air, bus or train in the past 14 days. _____(Initial)

I understand that any travel from any country outside of Canada, including travel by car, air, bus or train, significantly increases my risk of contracting and transmitting the novel coronavirus.
Provincial Health Services require self-isolation for 14 days from the date a person has returned to Canada. _____(Initial)

I understand that **Provincial** Health Services has asked individuals to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment.
______ (Initial)

I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by Provincial Health, the Communicable Disease Control or any other governmental health agency. _____ (Initial)

List of DENTAL TREATMENT

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above listed dental treatment completed during the COVID-19 pandemic.

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SIGNATURE OF PATIENT

Printed Name: __________________________________ Date: __________________