COVID-19 Pandemic Dental Treatment 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. _____ (Initial)

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 COVID-19 identified by Public Health Services: _____ (Initial)

- Fever > 38°C
- Cough (new or worsening chronic)
- Sore Throat
- Shortness of Breath
- Difficulty Breathing
- Flu-like symptoms
- Runny Nose
- Nausea / vomiting, diarrhea, abdominal cramps (or unknown origin)
- Conjunctivitis (Pink Eye)
- Decrease or loss of sense of taste or smell
- Chills
- Headaches
- Unexplained Fatigue / Malaise / Muscle Aches
- Pink Eye (Conjunctivitis)
- Runny nose / nasal congestion without other known cause

I confirm that I am not in a high risk category, including: diabetes, cardiovascular disease, hypertension, lung diseases including moderate to severe asthma, being immunocompromised, having active malignancy, or over age 65. _____ (Initial)

OR I fall into the following high risk category (_____) and my dentist and I have discussed the risks, and I agree to proceed with treatment. _____ (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 Ontario 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. Public Health requires self-isolation for 14 days from the date a person has returned to Canada. _____ (Initial)

I understand that Public Health has asked individuals to maintain physical 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 Public Health, the Communicable Disease Control or any other governmental health agency. _____ (Initial)

Dental Treatment (List)

_____

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. _____ (Initial)

_____
SIGNATURE OF PATIENT

Printed Name_____ Date_____