COVID-19 Pandemic Dental Treatment Consent Form

Patient name: ____

I confirm that me or my child (whoever has the appointment):

1) Does NOT have any of the following symptoms that have developed in the last 10 days AND are new or worsening?
   - Cough
   - Fever or chills
   - Shortness of breath, difficulty breathing or increased oxygen needs
   - Sore throat or painful swallowing
   - Stuffy or runny nose
   - Vomiting or diarrhea
   - Nausea or loss of appetite
   - Headache
   - Muscle or joint aches or pains
   - Feeling extremely fatigued / exhausted
   - Loss of or change to sense of smell or taste
   - Pink eye (conjunctivitis)
   - Changes to mental state such as confusion, memory loss or behavior changes

   ________________ (Initial)

2) Have NOT tested positive for COVID-19 in the past 14 days or are waiting for COVID-19 test results. And if I have to quarantine or have tested positive for COVID-19, I understand that I cannot enter a healthcare facility for 10 days or until my symptoms have resolved, whichever is longer. ________________ (Initial)

3) Have NOT been in close contact with someone who has tested positive for COVID-19 in the past 14 days. ________________ (Initial)

4) Are following all current regulations in regards to travelling in and out of Canada. ________________ (Initial)

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

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to having dental treatment completed.

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SIGNATURE OF PATIENT

Printed Name____________________________________ Date____________________