

## COVID-19 Pandemic Emergency 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.

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 have been made aware of the **Provincial** Dental Association and College guidelines that under the current pandemic all non-urgent dental care is not allowed. Dental visits should be limited to the treatment of ongoing tissue bleeding, alleviate severe pain or infection or conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3 to 6 months. \_\_\_\_\_ (Initial)

I confirm I am seeking treatment for a condition that meets these criteria. \_\_\_\_\_ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-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 emergency dental treatment completed during the COVID-19 pandemic.

\_\_\_\_\_  
SIGNATURE OF PATIENT

Printed Name \_\_\_\_\_ Date \_\_\_\_\_