COVID-19 PANDEMIC – PATIENT CONSENT FORM FOR TREATMENT

Patient name: _____

I understand the novel coronavirus causes the disease known as COVID-19. I understand this 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.

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, I have an elevated risk of contracting the novel coronavirus simply by being in a dental office.

I understand that Alberta Health Services 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 confirm that I am not presenting any of the following symptoms of COVID-19:

- Fever > 38°C _____ (Initial)
- Cough _____ (Initial)
- Sore Throat _____ (Initial)
- Shortness of Breath _____ (Initial)
- Difficulty Breathing _____ (Initial)
- Flu-like symptoms _____ (Initial)
- Runny Nose _____ (Initial)

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.

OR _____ (Initial)

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 and that I am not waiting for the results of a laboratory test for the novel coronavirus.

I verify that I have not returned to Alberta from any country outside of Canada whether by car, air, bus or train in the past 14 days.

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 Alberta Health, the Communicable Disease Control or any other governmental health agency.

_____ (Initial)

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

_____

SIGNATURE OF PATIENT

_____ _____

PRINTED NAME DATE

RENEWAL OF CONSENT FOR SUBSEQUENT DENTAL VISITS

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PATIENT DATE