PATIENT ACKNOWLEDGEMENT

COVID-19 PANDEMIC DENTAL RISK

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible.

(initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize it is not possible to maintain this distance while receiving dental treatment.

(initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that 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 visits of other 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 the dental office.

(initial)

I agree to complete a COVID-19 screening questionnaire as required by the Ministry of Health.

(initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative.

(initial)

If applicable, approximate date of test:

(initial)

I confirm that I am not waiting for the results of a test for COVID-19.

(initial)

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days.

(initial)

I confirm that I do NOT have andy TWO OR MORE of the following symptoms of COVID-19: fever, new or worsening cough, sore throat, runny nose or headache

(initial)

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

NAME OF PATIENT, PARENT, or GUARDIAN

E-mail

Date

Phone Number