

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 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, it is recommended to stay home and avoid close contact with other people when at all possible. _____ (initial)

I understand the federal and provincial governments have asked individuals to maintain social distancing of a least 2 meters (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 important 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 visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, **that I have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in the dental office**. _____ (initial)

I am aware that the Province of Ontario has, under the current pandemic, opened up elective (non-urgent) treatment to health care providers.

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

I confirm that I have not tested positive for COVID-19. _____ (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 where I required to self-isolate for 14 days. _____ (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.

PATIENT NAME: _____

SIGNATURE OF PATIENT _____ Date _____