COVID-19 Pandemic Dental Treatment Consent Form

First Name – Patient__________________________ Last Name – Patient _________________________

Patient birth date MM-DD-YYYY _____________________________

COVID – 19 Pandemic Dental Treatment Consent Form

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 and/or blood spray which is one way that the novel coronavirus can spread.

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.

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

- Fever > 38°C
- New cough or worsening chronic cough
- Sore throat or painful swallowing
- New or worsening shortness of breath
- Difficulty Breathing
- Flu-like symptoms
- Runny Nose

I confirm I know that there are categories of people who are high risk.

I understand the high-risk category factors are being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorder.

OR

I fall into the following high-risk categories and my dentist and I have discussed the risks, and I have agreed to proceed with treatment.

I confirm that I am not currently positive for the novel coronavirus.

I confirm 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 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.

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.

I verify the information I have provided on this form is truthful and accurate.

I knowingly and willingly consent to have the above listed dental treatment completed during the COVID-19

pandemic.

Print Name ____ X____________________________________