Forest Glen Dental COVID-19 Patient Consent Form

Patient name: _____ (print name)

Date: _____ (day/month/year)

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 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 COVID-19. _____ (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 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)

I verify that my temperature taken was taken today by a Forest Glen Dental Employee and registered as _____ **°C**

_____ (Initial)

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the dental treatment completed during the COVID-19 pandemic. I have had the opportunity to ask any questions I have regarding COVID-19 in relation to dental treatment. I also understand if you experience of symptoms of COVID-19, 14 days after my appointment I will contact Forest Glen Dental immediately.

Patient signature: _____