Patient Acknowledgement and screening: COVID-19 Pandemic Emergency Dental Risk

Please read the patient acknowledgement below, initial and sign.

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.

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.**

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.

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.**

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

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

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

I do not have any of the following symptoms: fever, cough, shortness of breath, sore throat, difficulty swallowing, decrease/loss of sense of smell or taste, chills, headache, fatigue, nausea or runny nose _____ (Initial)

Have you travelled outside of Canada in the past 14 days? Yes / No

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: _____

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

SIGNATURE OF PATIENT _____ Date

Adapted from Dental Association of PEI *COVID-19 Pandemic Emergency Dental Risk Acknowledge by Patient.*