



Patient Name: _____

COVID-19 PATIENT CONSENT FORM

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that some dental procedures create water spray and aerosols which is one way that the novel coronavirus can spread. Aerosols can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus.

I understand that despite all possible precautions, 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.

I understand that I am most vulnerable to COVID if I am over 70 years of age AND/OR have serious respiratory disease, serious heart conditions, immunocompromised conditions, severe obesity, diabetes, chronic kidney disease, liver disease and pregnancy and it is recommended to defer treatment if possible.

I confirm I still wish to continue to seek dental treatment today.

I confirm that I am not presenting any of the following symptoms of COVID-19: • Fever > 37.5 C, • Cough, • Sore Throat, • Shortness of Breath, • Flu-like symptoms, • Loss of sense of taste or smell 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 British Columbia from any country outside of Canada whether by car, air, bus or train in the past 14 days.

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 BC's Provincial Health Officer, the Communicable Disease Control or any other governmental health agency.

I understand that BC's Provincial Health Officer has asked individuals to maintain social distancing of at least 2 meters (6 feet) and it is not possible to maintain this distance and receive dental treatment.

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.

Signature: _____

Date: _____