PeacePark DenTaL

Patient Acknowledgement: COVID-19 Pandemic Emergency 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 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. __________ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of at least two (2) meters (six (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 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. __________ (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 the novel coronavirus simply by being in the dental office.** __________ (initial)

I confirm that I do NOT have any of the following symptoms of COVID-19: _______(INITIAL)

FEVER	WORSENING OF CHRONIC COUGH	SHORTNESS OF BREATH
DIFFICULTY OF BREATHING	DIFFICULTY SWALLOWING	SORE THROAT
DECREASE OR LOSS OF SENSE OF TASTE OR SMELL		CHILLS
HEADACHES	UNEXPLAINED FATIGUE	NAUSEA/VOMITING
PINK EYE	RUNNY NOSE/NASAL CONGESTION	COUGH

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 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 during which public health authorities required I self-isolate for 14 days. __________ (initial)

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

______________________________ SIGNATURE OF PATIENT

______________________________ Date

TEMPERATURE WILL BE TAKEN UPON ENTRY TO THE OFFICE ____________________ STAFF INITIALS _____