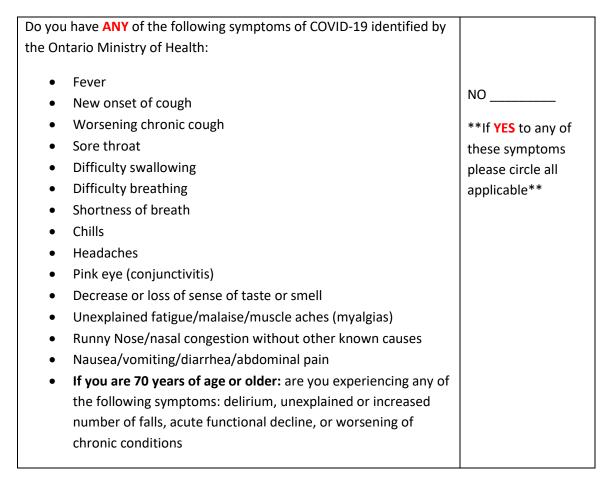


## **COVID-19 Pandemic Dental Treatment Consent**

Patient name: \_\_\_\_\_

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 dental procedures create water and/or blood spray which is one way that the novel coronavirus can spread. \_\_\_\_\_\_ (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 I know that there are categories of people who are considered to be 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. \_\_\_\_\_ (initial)

## 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. \_\_\_\_\_\_ (initial)

I confirm that I do not currently have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19 \_\_\_\_\_ (initial)

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. \_\_\_\_\_\_ (initial)

I confirm that I have not had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 day's \_\_\_\_\_\_ (initial)

I understand that the Ontario Ministry of Health has asked individuals to maintain physical distancing of at least 2 meters (6 feet) and it is not possible to maintain this distance and receive dental treatment. \_\_\_\_\_ (initial)

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.

SIGNATURE OF PATIENT (or Legal Guardian)

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_