COVID-19 Screening and Consent

NAME______________________________

I understand that COVID-19 may be present in a person not showing any symptoms and may be contagious. Initials _______

I understand it is not possible to maintain physical distancing of at least 2 meters (6 feet) while receiving dental treatment. Initials _______

I understand that due to aerosols produced with of some dental procedures, there may be an elevated risk of being exposed to the corona virus while in a dental office. Initials _______

PLEASE CONFIRM THAT YOU CURRENTLY <u>DO NOT HAVE</u> <u>OR</u> <u>HAVE NOT EXPERIENCED</u> ANY OF THE FOLLOWING SYMPTOMS OF COVID-19 IN THE PAST <u>10 DAYS.</u>	**PLEASE CONFIRM THAT YOU ARE NOT AT RISK FOR COVID-19 DUE TO EXPOSURE OR TRAVEL.**
➢ Fever ➢ Cough ➢ Sore throat ➢ Shortness of Breath ➢ Difficulty Breathing ➢ Flu-like symptoms o (ache, chills, fatigue) ➢ Runny nose Initials _______	➢ I am not COVID-19 positive. ➢ I am not waiting for a COVID test or the results of a recent test. ➢ I have not been asked to self-isolate for 14 days. ➢ I have not traveled outside of Canada in the past 14 days. ➢ I have not been identified as a contact of someone who tested positive for COVID-19 Initials _______

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS THAT MAY POSE AN INCREASED RISK FOR EITHER CONTRACTING CORONA VIRUS OR FOR COMPLICATIONS RELATED TO COVID-19 ILLNESS.

☐ Over the age of 65 ☐ Heart Disease ☐ Diabetes ☐ High Blood Pressure	☐ Lung Disease (including moderate to severe asthma) ☐ Active Cancer or Chemotherapy ☐ Auto Immune Disorder

If any of the above apply, I understand that I fall into a higher health risk category and I agree to proceed with dental treatment. Initials _______

*Please note: If you require additional information, or you would like to discuss this further with your dental care provider, please inform the receptionist.

I verify the information I have provided is truthful and accurate. I knowingly and willingly consent to proceed with today's dental treatment during the COVID-19 pandemic.

Signature ______________________________ **Date** ______________________