Endodontic Group
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COVID-19 Emergency Dental Treatment Consent Form

Patient Name: _____

I knowingly and willingly consent to have emergency or urgent dental treatment completed during the COVID-19 pandemic.

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

I acknowledge and understand that dental procedures create water 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)

I fall into one of the above high risk categories and I have discussed these risks with my dentist, and I have agreed to proceed with treatment.

_____(Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19:

- Fever > 38ºC _____(Initial)
- Cough _____(Initial)
- Sore Throat _____(Initial)
- Shortness of Breath _____(Initial)
- Flu-like symptoms _____(Initial)

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I confirm that I am not currently positive for the novel coronavirus.

_____(Initial)

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus.

_____(Initial)

I verify that I have not returned from any country outside of Canada in the past fourteen (14) days.

_____(Initial)

I understand that Public Health has asked individuals to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment.

_____(Initial)

I verify that I have not been identified as a contact of someone who has tested positive for COVID-19 or been asked to self-isolate by Public Health

_____(Initial)

LIST OF DENTAL TREATMENT

_____

_____

_____

_____

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

_____
SIGNATURE OF PATIENT

Printed Name: _____ Date: _____