



COVID-19 Pandemic Dental Treatment 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.

Please put your initials on marked spaces

I understand that dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____

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. _____

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 _____

I 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 understand that any travel from any country outside of Canada, including travel by car, air, bus or train, significantly increases my risk of contracting and transmitting the novel coronavirus. BC's Provincial Health Officer requires self-isolation for 14 days from the date a person has returned to Canada. _____

I understand that BC's Provincial Health Officer 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. _____

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

NAME OF PATIENT

SIGNATURE OF PATIENT

DATE