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Patient Acknowledgement Form: 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 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, it is recommended to stay home and avoid close contact with other people when at all possible	(Initials)
I understand the federal and provincial governments have asked individuals to maintain social distancing of a least 2 meters (6 feet) and I recognize it is **not possible to maintain this distance while receiving dental treatment**	(Initials)
I understand that it is possible that oral surgery/dental procedures can create water and/or blood spray, which may be 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.	(Initials)
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 AND SPREADING the novel coronavirus simply by being in the dental office.**	(Initials)
I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: fever, new or worsening cough, sore throat, runny nose, headache, recent loss of taste and smell.	(Initials)
I confirm that I have not tested positive for COVID-19 and not waiting for results of a test for COVID-19. I confirm that I have not been in contact with confirmed COVID-19 positive patient or persons self-isolating because of determined risk for COVID-19.	(Initials)
I confirm that I have NOT returned from any travel, and this is NOT currently a period where I required to self-isolate for 14 days.	(Initials)
I confirm that I have not been to a gathering of 15 or more people, in last 14 days	(Initials)
I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.	(Initials)

Patient name (please print): _____ Date: _____

Patient signature: _____ Temperature: _____