Patient Acknowledgement:

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 that 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, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible. \_\_\_\_\_\_\_\_ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize it is not possible to maintain this distance while receiving dental treatment. \_\_\_\_\_\_\_\_ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. \_\_\_\_\_\_\_\_ (initial)

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 the novel coronavirus simply by being in the dental office. \_\_\_\_\_\_\_\_ (initial)

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: (i) fever, (ii) new or worsening cough, (iii) sore throat, (iv) runny nose or (v) headache. \_\_\_\_\_\_\_\_ (initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. \_\_\_\_\_\_\_\_(initial). If applicable, approximate date of test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I confirm that I am not waiting for the results of a test for COVID-19. \_\_\_\_\_\_\_\_ (initial)

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. \_\_\_\_\_\_\_\_ (initial)

***I understand and agree to an additional fee of $18.00 per visit for Personal Protective Equipment to protect myself and my providers, that this additional charge WILL BE SUBMITTED to my insurance company on my behalf. I understand that my insurance MAY NOT COVER this and I am fully responsibility should there not be coverage. \_\_\_\_\_\_\_\_ (initial)***

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

Patient/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian’s SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adapted from Ontario Dental Association Return to Practice Toolkit (V3.0) *Patient Acknowledgement: COVID-19 Pandemic Emergency* *Dental Risk.*