Smile Centre
DENTAL

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. _____ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters 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 of the following symptoms of COVID-19:

- Fever
- New onset of cough or worsening of chronic cough
- Shortness of breath or difficulty breathing
- Sore throat or difficulty swallowing
- Decrease or loss of sense of taste or smell
- Chills
- Headaches
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain
- Pink eye (conjunctivitis)
- Runny nose/nasal congestion without other known cause

_____ (initial)

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

I confirm that I have not travelled outside of Ontario in the past 14 days. _____ (initial)

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

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

PRINT NAME: _____

SIGNATURE: _____ Date: _____