COVID-19 PANDEMIC PATIENT DENTAL TREATMENT CONSENT FORM

PATIENT NAME: _____ TEMP: _____

DENTIST /HYGIENIST: _____ CLINIC: VALLEY DENTAL GROUP

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

I understand that dental procedures create aerosols which is one way the covid-19 can spread. The ultra-fine nature of the aerosols can linger in the air for minutes to sometimes hours, which can transit covid-19. _____

I understand that due to the frequency of visits of other dental patients, the characteristics of covid-19, and the characteristics of dental procedures, that I have an elevated risk of contracting covid-19 simply by being in a dental office. _____

I have been made aware of the British Columbia Dental Association and the College of Dental Surgeons of British Columbia guidelines that under the current pandemic dental visits are to be limited to the treatment of emergencies, urgent conditions, and under most conditions procedures that limit aerosol production. _____

I confirm that I am not presenting with 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 or waiting for laboratory test results for the covid-19. _____

I verify that I have not returned to B.C. from any country outside of Canada whether by car, air, bus or train, In the past 14 days. _____

I understand that any travel to any country out side of Canada significantly increases my risk of contracting and transmitting covid-19. B.C.'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 covid-19 or been asked to self-isolate by the 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 have dental treatment completed during the covid-19 pandemic. I know that I'm required to contact the office if I exhibit any signs of COVID-19. _____

Sign: _____ Date: _____