

COVID-19 Pandemic Emergency Dental Treatment Consent Form

Patient name: _____

I understand the novel corona virus causes the disease known as COVID-19. I understand the novel corona 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 water spray which is one way that the novel corona virus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel corona virus. _____ (Initial)

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel corona virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel corona virus simply by being in a dental office. _____ (Initial)

I have been made aware of the NY State Department of Health and Dental Association guidelines that under the current pandemic all non-urgent dental care is not allowed. Dental visits should be limited to the treatment of ongoing oral bleeding, swelling, alleviate severe pain and/or infection or conditions that significantly inhibit normal functioning of teeth, mouth, and issues that may cause anything listed above within the next 3 months. _____ (Initial)

I confirm I am seeking treatment for a condition that meets these criteria. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by NY State Health Services:

- Fever > 38°C _____ (Initial)
- Cough _____ (Initial)
- Sore Throat _____ (Initial)
- Shortness of Breath _____ (Initial)
- Flu-like symptoms _____ (Initial)

I confirm that I am not currently positive for the novel corona virus. _____ (Initial)

I confirm that I am not waiting for the results of a laboratory test for the novel corona virus. _____ (Initial)

I verify that I have not returned to NY State from any country outside of Canada whether by car, air, bus or train in the past 14 days. _____ (Initial)

Date _____, 2020

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 corona virus. NY State Health Services require self-isolation for 14 days from the date a person has returned to Canada. _____
(Initial)

I understand that NY State Health Services has asked individuals to maintain social distancing of at least 2 meters (6 feet) and it is not possible to maintain this distance and receive dental treatment.
_____ (Initial)

I verify that I have not been identified as a contact of someone who has tested positive for novel corona virus or been asked to self-isolate by NY State Health, the Communicable Disease Control or any other governmental health agency. _____ (Initial)

LIST of DENTAL TREATMENT (see treatment plan)

Other:

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

SIGNATURE OF PATIENT

Printed Name _____ Date _____