Patient Acknowledgement: COVID-19 Pandemic
Risk with Dental Treatment

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. **I also understand that Dr. Lin and his team currently are conducting all dental cleaning by hand instruments only to minimize such spray.** _____ (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. **I also understand that Dr. Lin and his team are avoiding any spray-producing procedures if possible and they are using all precautions possible to eliminate dental aerosol from lingering in the dental office to minimize risks.** _____ (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. And I will notify Dr. Lin or staff if I developed the above symptoms within 14 days of my office visit.** _____ (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 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.

NAME OF PATIENT (Please PRINT) _____

SIGNATURE OF PATIENT _____Date _____