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COVID-19 Pandemic Dental Treatment Screening & Consent Form

1. Have you received your second/final vaccination dose more than 14 days ago?

   ☐ YES ☐ NO

2. Do you have any of the following symptoms?
   ☐ Fever and/or chills
   ☐ New onset of cough or worsening chronic cough
   ☐ Shortness of breath
   ☐ Decrease or loss of sense of taste or smell
   ☐ If adult 18+ years of age: unexplained fatigue/lethargy/malaise/muscle aches
   ☐ If child under 18 years of age: nausea/vomiting or diarrhea

3. Have you or anyone in your household tested positive for COVID-19 in the past 10 days or have you been told you should be isolating?

   ☐ YES ☐ NO

ONLY ANSWER THE FOLLOWING QUESTIONS IF YOU ANSWERED “NO” TO QUESTION 1 (i.e. you have not been fully vaccinated):

4. Have you travelled outside of Canada in the last 14 days?

   ☐ YES ☐ NO

5. Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

   ☐ YES ☐ NO

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus 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 and/or blood spray which is one way that the novel coronavirus can spread. _____ (Initial)

I understand that due to the frequency of visits of other dental 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 a dental office. _____ (Initial)

I understand that there are categories of people who are considered to be high-risk. The high-risk factors are being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder. _____ (Initial)
OR I fall into the following high-risk categories (_____) and my dentist and I have discussed the risks, and I have agreed to proceed with treatment. _____ (Initial)

I understand that Ontario Public Health has asked individuals to maintain physical distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment. _____ (Initial)

I verify the information I have provided on this form is truthful and accurate.

Patient Signature _____

Print Name _____

Date _____