Downtown Georgetown Dental

COVID-19 Pandemic Dental Treatment Consent

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 at 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 I might have an elevated risk of contracting the novel coronavirus by being in the dental office.
  _____ (initial)
- I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19:
  - fever
  - new or worsening cough
  - sore throat
  - runny nose
  - headache.

  _____ (initial)
- If I received COVID-19 test results in the past three (3) months, the last results I received were negative. If applicable, approximate date of test: _____
  _____ (initial)
- 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 surgical/dental treatment completed during the COVID-19 pandemic.

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____ DATE: _____