SWEET SMILES
FAMILY DENTISTRY AND ORTHODONTICS

COVID-19 Pandemic Dental Treatment Consent Form

I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic and post pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can possibly transmit the COVID-19 virus.

I confirm that I am not presenting any of the following symptoms of COVOID-19 :

- Fever > 100F/38C - Persistent
- Dry Cough
- Sore Throat
- Shortness of Breath or Difficulty Breathing
- Flu-like symptoms
- Unexplained Loss of Smell or Taste
- Diarrhea
- Runny Nose
- Tiredness/ Fatigue

_____Initials

I confirm that I am not currently positive for the novel coronavirus.
I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus.

I verify that I have not traveled to another state or country whether by car, air, bus or train in the past 14 days.

I understand that any travel from any other state or country, including travel by car, air, bus or train, significantly increases my risk of contracting and transmitting the novel coronavirus and may require self-isolation for 14 days from the date a person has returned.

I understand that individuals were asked 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 novel coronavirus or been asked to self-isolate by the Communicable Disease Control or any other governmental health agency.

Your Health and Your Immune System

A weak or compromised immune system can put you at greater risk for contracting COVID-19 (including, but not limited to, diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any other prior or current disease or medical conditions). Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

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

Patient Signature: _____

Signature Date: _____