COVID-19 Patient Pre-Screening Form

Palermo Village
DENTAL
DR. CHRISTOPHER BLAIR

Due to the COVID-19 Pandemic we have instituted an additional dental treatment consent form.

Patien'st name: ____ E-mail: ________________________________

I understand the novel coronavirus causes the disease known as COVID-19. I understand 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 that dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. ___________ **(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 confirm that I am not currently positive for the novel coronavirus. ___________ **(Initial)**

I confirm that I am not experiencing any flu-like symptoms in the last 14 days: ___________ **(Initial)**

- Cough
- Shortness of Breath
- Fever > 38°C
- Chills
- Sore Throat
- Repeated Shaking
- Fatigue
- Muscle Aches Vomiting
- Headache
- New loss of taste or smell
- Malaise
- Nausea
- Diarrhea

☐ Yes, I am awaiting a lab test for COVID-19.

☐ Yes, I have tested positive for COVID-19
Date Tested Positive: ____________________________

☐ Yes, I or a family member have been asked to self-isolate or self-quarantine in the past 14 days.

☐ Yes, I have had close contact to an individual diagnosed with COVID-19 infection in the past 14 days.

☐ Yes, I have travelled outside Ontario in the past 14 days to a region with high rates of COVID-19

If you have answered yes to any of the above questions, delay elective treatment for 14 days, then re-evaluate.

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 coronavirus. Public Health requires self-isolation for 14 days from the date a person has returned to Canada. ___________ **(Initial)**

I understand that Ontario Health Services 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. I knowingly and willingly consent to have dental treatment during the COVID-19 pandemic. __________ **(Initial)**

________________________________ ______________________________________ ___________________

SIGNATURE OF PATIENT | Printed Name | Date