

COVID-19 Pandemic Dental Treatment Consent Form

Email to: countryhillsdental@shaw.ca or press SUBMIT at bottom

Patient name: _____

CMOH Order [05-2020](#) legally obligates any person who has the following: cough, fever, shortness of breath, runny nose, or sore throat (that is not related to a pre-existing illness or health condition) to be in isolation (quarantine) for 10 days from the start of symptoms, or until symptoms resolve, whichever takes longer. If they are exhibiting any of these symptoms, it is suggested they complete the [COVID-19 Self-Assessment online tool](#)

| | Initial |
|---|---------|
| 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 | |
| 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 | |
| I confirm that I am not presenting any of the following symptoms of COVID-19 identified by Alberta Health Services: | |
| Fever Recorded temperature: | |
| New or worsening shortness of breath | |
| Sore throat or painful swallowing | |
| New or worsening shortness of breath | |
| Difficulty breathing | |
| Flu-like symptoms | |
| Runny nose | |
| I confirm I know that there are categories of people who are considered to be high risk . I understand the high-risk category factors are being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder | |
| 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 | |
| I confirm that to my knowledge 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 that was ordered due to contact tracing or because I had identified risk factors | |
| I verify that I have not returned to Alberta from any country outside of Canada whether by car, air, bus, boat or train in the past 14 days | |
| I understand that any travel from any country outside of Canada significantly increases my risk of contracting and transmitting COVID-19. Alberta Health Services requires self-isolation for 14 days from the date a person has returned to Canada. | |
| I understand that Alberta 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 | |
| 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 Alberta Health, the Communicable Disease Control or any other governmental health agency | |
| Or | |
| I verify that I am a healthcare worker who has worn appropriate PPE | |
| I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above listed dental treatment completed during the COVID-19 pandemic. | |
| PATIENT SIGN:(in office) _____ DATE: _____ | |