Office Use:

Temperature: _____ °F

COVID-19 Pandemic Dental Treatment Screening and Consent Form

Patient Name: _____ Date: _____

Due to the current global situation, Courtside Dental holds the responsibility of making our patients aware of the risks of visiting a dental office during a pandemic. The information provided to you can then be used to make an informed decision regarding your health. Please read each of the following statements carefully and initial next to each to indicate you understand and/or the statement is true.

✔ I understand that a novel coronavirus causes the virus known as COVID-19. I understand that this particular virus has a long incubation period during which carriers of the virus may not show symptoms and still may be contagious. It typically takes about 5-6 days to show symptoms, but can take up to 14 days. Even though there may be mild symptoms present, or no symptoms at all, an individual can still unknowingly have the virus and be spreading it to others. **____Initial**

✔ I understand that for most people, the COVID-19 infection will cause mild illness however, it can make some people very ill and, in some people, it can be fatal. Older people and those with pre-existing medical conditions (such as cardiovascular disease, chronic respiratory disease, hypertension or diabetes) are at a high-risk for contracting the virus. **____ Initial**

✔ I understand that most dental procedures create an aerosol spray, which can settle on objects and surfaces, and even be breathed in. The virus can live on surfaces for many hours, and by touching an infected surface and then touching the mouth or nose, I can contract the virus and then spread it to others. **____ Initial**

✔ I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the nature of dental procedures, that I have an elevated risk of contracting the virus from simply being in a dental office. **____ Initial**

✔ I confirm that I am not presenting any of the following symptoms of COVID-19 as identified by the Saskatchewan Health Authority (SHA): (Initial stating that you **DO NOT** have these symptoms)

- Cough **___ Initial**
- Fever greater than 38°C (104°F) **___ Initial**
- Shortness of breath **___ Initial**
- Difficulty breathing **___ Initial**
- Flu like symptoms **___ Initial**
- Runny nose **___ Initial**

✔ I confirm that I am not currently positive for the novel coronavirus (COVID-19). **____ Initial**

✔ I confirm that I am not currently waiting for the results of a medical laboratory test for the novel coronavirus (COVID-19). **____ Initial**

✔ I verify that I have not returned to Saskatchewan from any country outside of Canada whether it be by car, air, bus, or train in the past 14 days (2 weeks). **____ Initial**

✔ 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 virus. Saskatchewan Health Services require self-isolation for 14 days (2 weeks) from the date a person has returned to Canada. **____ Initial**

✔ I understand that the Saskatchewan Health Authority has asked individuals to maintain a physical distance of at least 2 meters (6 feet) and it is not possible to maintain this distance and receive dental treatment. **____ Initial**

✔ 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 Saskatchewan Health Authority (SHA), Communicable Disease Control, or any other governmental health agency. **____ Initial**

✔ I understand that **ONLY** the patient seeking treatment will be permitted to enter the clinic. There will be an exception for patients that require a special caretaker. If this is the case, the caretaker will only be permitted to remain in the waiting room. **____ Initial**

✔ I understand that if I am bringing my child to an appointment, I will need to remain in my vehicle and only the child will be permitted to enter. When the appointment is complete, we will call and allow you to enter the clinic and pay and/or sign the necessary claim forms if applicable. **____ Initial**

✔ Only the dentist, assistant, and the patient receiving treatment will be allowed in the operatory, **NO EXCEPTIONS! ____ Initial**

✔ I agree that I need to wear footwear that allows me to wear socks as bare feet are not allowed in the clinic. You may wish to bring along a pair of socks if your footwear does not allow this. **____ Initial**

I confirm that:

✗ I do not have any underlying medical conditions such as diabetes, cardiovascular disease or hypertension (high blood pressure). **____ Initial**
✗ I do not have any chronic respiratory diseases (including moderate to severe asthma). **____ Initial**
✗ I am not immunocompromised. **____ Initial**
✗ I do not have an active malignancy. **____ Initial**
✗ I am not over the age of 65. **____ Initial**
✗ I understand that the above conditions place me in a **high risk category. ____ Initial**

(if answer is yes to any risk category in the above statement)

I fall into the following high-risk category, _____ and my dentist and I have discussed the risks, and I have made the informed decision to proceed with the treatment. **____ Initial**

I verify that the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have my emergency dental treatment completed during the COVID-19 pandemic at Courtside Dental.

Patient Name (printed): _____

Patient Signature:_____

Signature of Parent or Guardian if under 18 years old: _____

Relationship: _____