DR. SARA SHIEWITZ
DENTISTRY

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COVID-19 Dental Treatment Consent Form

Patient name: _____

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 dental procedures create water and/or blood spray which is one way that the novel coronavirus can spread
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 presenting any of the following symptoms of COVID-19 identified by Ontario Public Health Services: (Please initial only if you have symptoms)

- Fever > 38°C _____ (Initial)
- Chills _____Initial
- Headaches_____Initial
- New cough or worsening chronic cough _____ (Initial)
- Sore throat or difficulty swallowing _____ (Initial)
- New or worsening shortness of breath _____ (Initial)
- Difficulty Breathing _____ (Initial)
- Flu-like symptoms _____ (Initial)
- Runny Nose/nasal congestion without other known cause _____(Initial)
- Decrease or loss of sense of smell or taste_____(Initial)
- Muscle aches_____(Initial)
- Unexplained fatigue/malaise_____(Initial)
- Nausea/vomiting/diarrhea/abdominal pain_____(Initial)
- Pink eye (conjuncitivitis)_____(Initial)

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. I fall into the following high risk categories

_____

I confirm that I am not currently positive for the novel coronavirus.
_____ (Initial)
I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. _____ (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 Ontario Public Health Services, or any other governmental health agency. _____ (Initial)

I verify the information I have provided on this form is truthful and accurate.
Print Name _____
Date_____