

Parkgate Village Dental Centre  
Dr. Jan. V. Khanansho

## Patient Pre-Screening and Dental Treatment Consent Form

Patient's Full Name: \_\_\_\_\_ Patient Temperature (OFFICE USE ONLY): \_\_\_\_\_

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus 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 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:

- Fever > 37.5 C \_\_\_\_\_(Initial)
- Chills \_\_\_\_\_(Initial)
- Cough \_\_\_\_\_(Initial)
- Sore Throat \_\_\_\_\_(Initial)
- Shortness of Breath. \_\_\_\_\_(Initial)
- Cold/Flu-like symptoms \_\_\_\_\_(Initial)
- Loss of Smell \_\_\_\_\_(Initial)
- Loss of Taste \_\_\_\_\_(Initial)
- Diarrhea \_\_\_\_\_(Initial)

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 BC's Provincial Health Officer, the Communicable Disease Control or any other governmental health agency. \_\_\_\_\_(Initial)

# Dental Treatment Consent Form

**LIST OF DENTAL TREATMENT(S):**

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.

**SIGNATURE OF PATIENT** \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_