Dr. Anne Starr & Associates

Patient COVID-19 Pandemic Risk Consent

Please read the patient acknowledgment below and initial or sign in all areas indicated.	**Initial**
I confirm that I do NOT have any of the following symptoms of COVID-19 such as: fever, new or worsening cough, sore throat, runny nose or lingering headache.	
I confirm that I have not tested positive for COVID-19.	
I confirm that I am not waiting for the results of a test for COVID-19.	
I confirm that this is not currently a period where I require to self isolate for 14 days.	
I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures**, that I have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in a dental office.**	
I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic, I understand the novel coronavirus has a long incubation period during which carries of the virus ***may not show symptoms and still be contagious***. For this reason, it is recommended to stay home and avoid close contact with other people when at all possible.	
I understand the federal and provincial governments have asked individuals to maintain social distancing of at least 2 meters (6 feet) and I recognize it is not possible to maintain this distance while receiving dental treatment.	
I understand that it is possible that oral surgery/dental procedures can create waters and/or blood spray, which may be 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.	
I agree that I will contact the office if any COVID-19 symptoms develop 14 days post treatment.	
I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic	

To ensure the safety of our patients and staff our office has implemented an appointment protocol. We highly recommend reviewing this prior to your appointment.

Patient Name:_____

Patient Signature:_____Date:_____

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