COVID-19 Pandemic Dental Treatment Consent Form

Patient Name: _____

Have you experienced any of the following symptoms in the last 14 days?

SYMPTOMS

Fever >38 C	☐ Yes	☐ No
New or worsening cough	☐ Yes	☐ No
Sore throat or painful swallowing	☐ Yes	☐ No
New or worsening shortness of breath	☐ Yes	☐ No
Difficulty breathing	☐ Yes	☐ No
Flu-like symptoms	☐ Yes	☐ No
Runny Nose	☐ Yes	☐ No

☐ I confirm that to my knowledge I am not currently positive for COVID-19 and I am not awaiting results of a lab test for COVID-19

☐ I verify that I have not been identified as a close contact of someone who has tested positive for the Novel Coronavirus or been asked to self-isolate by Alberta Health, the communicable Disease Control, or any other government agency.

I verify the information I have provided on this form is truthful and accurate.

_____ _____

Signature **Date**