HOUSTON DENTAL
dentistry for people who love to smile

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PATIENT COVID-19 ASSESSMENT and CONSENT FORM

Patient Name:_____ Date:_____ Forehead Temp. _____

I am not waiting for the results of a Lab test for Covid-19, or tested positive for Covid-19 or been asked to self isolate for 14 days._____

I have not had close contact with a confirmed case of COVID-19 or anyone asked to self isolate for 14 days._____

I have not, nor has anyone I have been in contact with, to the best of my knowledge, returned to Ontario from another country in the past 14 days._____

I have not had any of the following symptoms in the last 14 days: Fever, new onset of cough, worsening chronic cough, difficulty breathing, shortness of breath, Sore throat, Difficulty in swallowing._____

I have not had: a Decrease in sense of taste or smell, Chills, Headaches, Unexplained Fatigue, Malaise or Muscle aches, Nausea, Vomiting, or Diarrhea, Abdominal pain, or Pinkeye (conjunctivitis) Runny nose, or Nasal congestion without other known cause. _____

I understand these questions are asked as a screening prior to my appointment for the safety of myself, other patients, and the Houston Dental Staff. I will contact the office if I do develop any of these symptoms listed above in the next 14 days.

Email: _____ Cell#_____

COVID-19 DENTAL TREATMENT RISK ACKNOWLEDGEMENT

I understand the novel coronavirus causes the disease known as COVID-19, the nature of how it can be transmitted, and that it is currently a pandemic. I understand that 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 the federal and provincial authorities have asked individuals to maintain social distancing of at least 2 metres / 6 feet. I recognize it is not possible to maintain this distance while receiving dental treatment, therefore increasing the risk of contracting the novel coronavirus._____

I understand that patients having a high risk medical history, including: diabetes, cardiovascular disease, hypertension, lung diseases such as moderate to severe asthma, being immunocompromised, having active malignancy, and being over the age of 65 pose an increased risk for life threatening complications if infected with COVID-19._____

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to having dental treatment completed during the COVID-19 pandemic.

Signature of Patient: _____ Date:_____