British Columbia Dental Association
MEMBER OF THE CANADIAN DENTAL ASSOCIATION

Patient Acknowledgement Form: COVID-19 Pandemic Emergency Dental Risk

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. 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.*** For this reason, it is recommended to stay home and avoid close contact with other people when at all possible	(Initials)
I understand the federal and provincial governments have asked individuals to maintain social distancing of a least 2 metres (6 feet) and I recognize it is **not possible to maintain this distance while receiving dental treatment**	(Initials)
I understand that it is possible that oral surgery/dental procedures can create water 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.	(Initials)
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 the dental office.**	(Initials)
I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: fever, new or worsening cough, sore throat, runny nose or headache	(Initials)
I confirm that I have not tested positive for COVID-19.	(Initials)
I confirm that I am not waiting for the results of a test for COVID-19.	(Initials)
I confirm that this is not currently a period where I required to self-isolate for 14 days.	(Initials)
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.	(Initials)

Signature of patient: ______________________________ Date: ________________

Payment Authorization

Patient Name: ____________________ Credit Card No: ______________________________

Expiry: _____/_____ CVV Code (3 digits on back of card): ____________

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