



Windsor Dental Care
Dr. Mark Luvisotto
2224 Walker Rd. Suite 20
Windsor, ON N8W-5L7
226 773 1370

COVID-19 Pandemic Emergency Dental Treatment Consent Form

Patient name: _____

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

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 the novel coronavirus, and 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 identified by **Provincial** Health Services:

- Fever > 38°C _____ (Initial)
- Cough _____ (Initial)
- Sore Throat _____ (Initial)
- Shortness of Breath _____ (Initial)
- Flu-like symptoms _____ (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 returned to **Ontario** from any country outside of Canada whether by car, air, bus or train in the past 14 days. _____ (Initial) I understand that any travel from any country outside of Canada, including travel by car, air, bus or train, significantly increases my risk of contracting and transmitting the novel coronavirus. **Provincial** Health Services require self-isolation for 14 days from the date a person has returned to Canada. _____ (Initial)

I understand that **Provincial** Health Services has asked individuals to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment. _____ (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 **Provincial** Health, the Communicable Disease Control or any other governmental health agency. _____ (Initial)

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

_____ SIGNATURE OF PATIENT Printed name _____

Date _____