

## Patient Acknowledgement of COVID-19 Pandemic 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 <b>may not show symptoms and still be contagious</b> . 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 <b>not possible to maintain this distance while receiving dental treatment</b> .	(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.	(Initials)
I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, <b>that I have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in the dental office</b> .	(Initials)
I understand that people with pre-existing conditions such as serious respiratory disease, serious heart conditions, immunocompromised conditions, severe obesity, diabetes, chronic kidney disease or those undergoing dialysis, and liver disease; pregnant patients; and patients who are 70 years and over are considered high risk for severe COVID-19. I understand the extra risk and I prefer to proceed with my dental care.	(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 I am not currently in the midst of completing a mandatory 14 day self-isolation.	(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: \_\_\_\_\_

Adapted from Dental Association of PEI *COVID-19 Pandemic Emergency Dental Risk Acknowledge by Patient*.