Patient Acknowledgement COVID-19

Treatment Consent

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

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.** \_\_\_\_\_\_\_\_\_\_ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one possible way that the novel coronavirus can spread. . \_\_\_\_\_\_\_\_\_\_ (initial)

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, **that I may have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in the dental office. \_\_\_\_\_\_\_\_\_\_** (initial)

I verify the information I have provided on this form and during the other screening questions I have been asked is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

SIGNATURE OF PATIENT  Date

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