Dr. Sue Ann Choo
REDISCOVER YOUR INNER SMILE

Patient Acknowledgement: 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 that the novel coronavirus virus has a long incubation period during which carriers of the virus ***may not show symptoms and still be contagious.*** ○ Yes ○ No

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize it is **not possible to maintain this distance while receiving dental treatment.** ○ Yes ○ No

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. ○ Yes ○ No

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 the novel coronavirus simply by being in the dental office.*** ○ Yes ○ No

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: (i) fever, (ii) new or worsening cough, (iii) sore throat, (iv) runny nose or (v) headache. ○ Yes ○ No

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. ○ Yes ○ No ○ Not Applicable
If applicable, approximate date of test: _____

I confirm that I am not waiting for the results of a test for COVID-19. ○ Yes ○ No

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. ○ Yes ○ No

Upon arriving at the office, you will be asked to:

- Wear a mask. In the event that you do not have your own we will provide you with one.
- Sanitize your hands with provided sanitizer.
- Possibly have your temperature taken with a no-contact infrared thermometer.
- Confirm the patient screening questions.

Please be advised that only patients with an appointment will be permitted to enter the office. To promote social distancing, please also do not arrive too early or too late for your scheduled appointment by either waiting in your vehicle and calling the office when you arrive.

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

Completed by: _____ _____ _____
First Name Last Name Date

_____
SIGNATURE

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

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Patient Screening Form

Patient name:
Who answered: ☐ Patient ☐ Other (specify)
☐ Phone ☐ Email ☐ Other (specify)

SCREENING QUESTIONS

Have you had close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days?

◯ Yes ◯ No

Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?

◯ Yes ◯ No

Do you have any of the following symptoms:

- Fever
- New onset of cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Difficulty swallowing
- Decrease or loss of sense of taste or smell
- Chills
- Headaches
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain
- Pink eye (conjunctivitis)
- Runny nose/nasal congestion without other known cause

◯ Yes ◯ No

Are you 70 years of age or older, experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

◯ Yes ◯ No

SIGNATURE

Date