WELLNESS SCREENING

COVID-19 Treatment Consent Form

Patient name: _____

DOB (MM/DD/YYYY): _____

Parents name (if applicable): _____

Email: _____

Phone: _____

I understand that the novel coronavirus causes the disease known as COVID-19. I understand that the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that some dental procedures create water spray which is one way that the novel coronavirus may spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours. This may 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, I have an elevated risk of contracting the novel coronavirus simply by being in a dental office. _____ (Initial)

I have been made aware of the Provincial Dental Board of Nova Scotia's May 27,2020 guidelines. I understand that, due to the current pandemic, all non-urgent and non-emergent dental care is not allowed._____ (Initial)

I confirm I am seeking treatment for an urgent or an emergent condition. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by:

- Fever > 38°C (Initial)
- Cough (Initial)
- Sore Throat (Initial)
- Shortness of Breath (Initial)
- Difficulty Breathing (Initial)
- Flu-like symptoms (Initial)
- Runny Nose (Initial)
- Headache (Initial)

I confirm that I do not have any of the following medical conditions which would put me in a high risk category: diabetes, cardiovascular disease, hypertension, lung diseases including moderate to severe asthma, being immunocompromised, having active malignancy, or over age 60. _____ (Initial)

OR

I do have some/all of the medical conditions listed above and my dentist and I have discussed the risks, and I agree to proceed with treatment. _____ (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 Nova Scotia from anywhere outside of the Province whether by car, air, bus or train in the past 14 days. _____ (Initial)

I understand that any travel from anywhere outside of Nova Scotia requires self-isolation for 14 days from the date a person has returned to Nova Scotia. _____ (Initial)

I understand that Nova Scotia's Chief Medical Officer of Health has asked individuals to maintain physical distancing of at least 2 metres (6 feet) and that 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 the novel coronavirus or been asked to self-isolate by the Province of Nova Scotia or any other governmental health agency. _____ (Initial)

I verify that the information I have provided on this form is truthful and accurate. If the answer to any of these questions changes before the appointment, I agree to notify Embrace Orthodontics as soon as possible. If the answer is yes to any of the previous questions, I understand that I will be asked to reschedule the appointment. I knowingly and willingly consent to have the above listed emergency or urgent dental treatment completed during the COVID-19 pandemic. _____ (Initial)

Treatment Consent: Please, be assured that our office has always met or exceeded the requirements for sterilization and infection control from the Federal and Provincial Health Authorities and will continue to do so. Our office will provide socially distant appointment scheduling, and also has added a number of new technologies and techniques to the practice to enhance the level of safety. However, it is possible to contract COVID-19 infection (or any other communicable disease) in any public space. Due to the nature of orthodontic treatment, a 6 foot distance is not possible between the orthodontic patient and clinical staff/doctor. Re-entering public life comes with some risks that we all must weigh,

but we also want you to feel confident that our office is taking every step to keep our patient and staff safe during this difficult time. I consent to receiving orthodontic treatment at Embrace Orthodontics. _____(Initial)

SIGNATURE OF PATIENT

Printed Name **Date**

SIGNATURE OF DENTIST

Printed Name **Date**