Lacombe Park Dental and the Alberta Dental Association Pre-Screening Patient Consent

Patient Name:_____ **Patient age:**_____

Screening Questions:	Prior to visit (patient use)	In office (Staff use only)
1. Do you have a fever or have felt hot or feverish anytime in the last 10 days?	YES NO	YES NO
Pre-Screen In-Office Patient temperature at appointment: _____.(staff use only)		
2. Do you have any of these symptoms: New or worsening cough? New or worsening shortness of breath? Difficulty breathing? Sore throat or painful swallowing? Runny nose?	YES NO	YES NO
3. Have you experienced a recent loss of smell or taste?	YES NO	YES NO
4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?	YES NO	YES NO
5. Have you returned from travel outside of Canada in the last 14 days?	YES NO	YES NO
6. Have you returned from travel within Canada from a location known affected with COVID-19 in the last 14 days?	YES NO	YES NO
7. Is your workplace considered high risk?	YES NO	YES NO
8. Are you over the age of 65?	YES NO	YES NO
9. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	YES NO	YES NO

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

_____

SIGNATURE OF PATIENT/GUARDIAN

Printed Name_____Date_____