COVID-19 Pandemic Dental Treatment Screening & Consent Form
Asante Dental Centre – New Westminster

Patient Name			
Current Status		**Yes**	**No**
Do you have any of the following symptoms or have had these symptoms in the past 14 days	Fever > 38°C		
	Cough		
	Any Flu-like Symptoms		
	Sore Throat		
	Shortness of Breath		

Please Read & Initial Each Line	Initial
I understand the novel coronavirus known as COVID-19 has a long incubation period, during which carriers of the virus may not show symptoms and still be contagious.	
I understand that dental procedures create water spray and is one way in which COVID-19 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.	
I understand that due to the frequency of visits of other dental patients, the characteristics of COVID-19, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.	
I understand that if I am over the age of 70, or if I have heart disease, lung disease, kidney disease, diabetes or any immunocompromised status, or chronic condition, this puts me at an elevated risk of complications from contracting COVID-19.	
I have been made aware of the British Columbia Dental Association, College of Dental Surgeons of BC, and the BC Provincial Health Guidelines that dental care has been approved to resume as a part of the Phase 2 opening pandemic plan.	
I confirm that I am not currently positive for COVID-19 nor am I waiting for results for a laboratory test to confirm if I have COVID-19.	
I verify that I have not returned to British Columbia from any country outside of Canada, whether by car, air, bus or train in the past 14 days.	
I understand that BC Public Health has asked individuals to maintain social distancing of at least 2 meters (6 feet) and it is not possible to maintain this distance and receive dental treatment.	
I verify that I have not been identified as a contact of someone who has tested positive COVID-19 or been asked to self-isolate by BC Public Health.	
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 knowing the risks.	

FULL NAME: _____

SIGNATURE OF PATIENT: _____ **DATE:** _____