Covid 19 Disclosure and Consent

Patient Name: **Temperature:**

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes No
Are you/they having shortness of breath or other difficulties breathing?	Yes No
Do you/they have a cough?	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No
Have you/they experienced recent loss of taste or smell?	Yes No
Are you/they in contact with any confirmed COVID-19 positive patients? ***Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.***	Yes No
Is your/their age over 60?	Yes No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

I have discussions with my doctor in regards to the pros and cons relating to contracting COVID- 19. I am satisfied that my doctors answered all of my questions.
Although there are no guarantees in regards to the possibility of contracting COVID- 19, my doctor will be following safety protocols as to best protect myself and the staff during the visit. I understand that I have possibility to delay my treatment and I have elected to have the procedure at this time.

Patient Signature:_____ **Date:**_____