YUKON DENTISTRY

COVID-19 Pandemic Dental Treatment Consent Form

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 dental procedures create water and/or blood aerosol, and that this aerosol may be capable of transmitting the novel coronavirus.

I understand that there are other patients receiving dental care, and due to 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.

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

- Fever >38℃, current or within the last 10 days
- New cough or worsening chronic cough
- Sore throat or painful swallowing
- New or worsening shortness of breath
- Runny nose
- Flu-like symptoms
- Loss of taste or smell

I confirm I know that there are categories of people who are considered to be high risk. I understand the high risk category factors are being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder.

I confirm that I have not currently tested positive for the novel coronavirus.

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus.

I understand that any travel from any country outside of Canada, the Federal Government requires travellers to self-isolate for 14 days from the date a person has returned to Canada.

I understand that Yukon Territorial Health Services has asked individuals to maintain a physical distance of at least 2 metres (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 for novel coronavirus or been asked to self-isolate by Yukon Territorial Health, the Communicable Disease Control or any other governmental health agency.

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

SIGNATURE OF PATIENT_____

Printed Name:_____ Date_____