COVID-19

TREATMENT CONSENT FORM

Patient Name	Test Patient

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 due to the frequency of visits of other denturist patients, the characteristics of the novel coronavirus, and the characteristics of denture procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a denturist office.

Question	Answer
I have a fever greater than 38°C / 100°F	Yes
I have a new cough	Yes
I have shortness of breath	Yes
I have flu-like symptoms	Yes
I have tested positive for the novel coronavirus	Yes

I tested positive on this date	**I have since been confirmed negative**
2020-10-16	No

Question	Answer
I am currently waiting for the results of a laboratory test for the novel coronavirus.	Yes
I have been outside the country in the past 14 days.	Yes
I have diabetes	Yes
I have respiratory problems	Yes
I have an autoimmune disorder	Yes

✔ I understand it is recommended to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive denture 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 any governmental health agency.

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

Patient Signature

Test