

CLAYHALL DENTAL CARE

COVID-19 PANDEMIC DENTAL TREATMENT PATIENT CONSENT FORM

Issued in the interest of self-protection of the patients and the dental personnel

I _____ knowingly and willingly consent for myself or for a minor _____ under my care to have elective dental or emergency dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine per patient/person.

Dental procedures take place with the patient in very close proximity to the service provider. This potentially exposes the patient and the operator to saliva and to coolant water spray, which may spread the disease. The ultra-fine nature of the spray and droplets may linger in the air, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in the practice.

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

- Raised temperature
- Shortness of Breath
- New persistent cough
- Loss or change in my normal sense of smell or taste

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus.

I verify that I have not travelled outside the United Kingdom or been repatriated in the past 14 days to or from countries that have been affected by COVID-19.

Although there are no guarantees in regard to the possibility of contracting COVID-19, my dentist and his staff will be following strict safety protocols as to best safeguard myself and the staff during treatment. I understand that I have the possibility to delay my treatment, and I have elected to have the procedure at this time

Signature: _____ Date: _____