Dr. Maneesh Rai's Dental Clinic, BHOPAL

COVID-19 Pandemic Emergency Dental Treatment Consent Form

Patient Name: _____Age _____ Years Gender _____

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 spray which is one way that the novel coronavirus 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 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 identified by World Health Organization:

- Fever higher than 38°C
- Cough
- Sore Throat
- Shortness of Breath
- Difficulty Breathing
- Flu-like symptoms
- Change in Smell/Taste
- Runny Nose

I confirm that I am not in a **high-risk category**, including diabetes, cardiovascular disease, hypertension, lung diseases including moderate to severe asthma, being immunocompromised, having active malignancy, or over age 65.

OR

I fall into the following high-risk category and my dentist and I have discussed the risks, and I agree to proceed with treatment.

I confirm that I am not currently positive for the novel coronavirus. I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. I confirm I was not in contact with a COVID19 Positive case in last 15 days. I confirm that I do not live in a containment area/zone. I confirm I have not been asked by authorities or require by regulations to be quarantined.

I understand that Government of India has asked individuals to maintain physical distancing 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 authorities.

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

_____

SIGNATURE OF PATIENT

Printed Name_____ ID : DHCC _____ Date_____