NEW CROSS
DENTAL PRACTICE

Patient Consent for Treatment During COVID-19 Pandemic

I _________________________ (patient name) understand that I am opting for an elective dental treatment / procedure____

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization (WHO) and that the COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and as a result, social distancing is recommended. This is not entirely possible with my proposed treatment; however, I am satisfied that the safety measures are in place to minimise risk as much as possible, and patient contact will be kept to an absolute minimum in line with medical/dental need.

I understand the Management and Clinical staff are closely monitoring the COVID-19 situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective dental procedure, and I give my permission to proceed.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and will be highly contagious. I understand that COVID-19 can cause additional health risk, some of which may not currently be known at this time, in addition to those risks associated with the dental procedure itself

I have been given the option to defer my dental treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long term complications related to COVID-19 and I would like to proceed with my desired dental treatment

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

- Fever
- Shortness of breath
- Loss of sense of taste and/or smell
- Cough
- Flu-like symptoms such as stomach upset, headache or fatigue

I also confirm that I have not been in contact with any confirmed covid-19 positive patients within the last 14 days.

I confirm that If I develop COVID-19 symptoms following my dental treatment or a known contact of mine develops symptoms I will immediately inform NEW CROSS DENTAL PRACTICE to enable appropriate measures to be put in place and contact tracing to commence. I hereby authorise the dentist and any associates to perform the following procedure.

Dentist's Name (please print):	**Dentist Signature:**	**Date:**
_________________________	_________________________	____________
Patients Name (please print):	**Patient/Guardian Signature:**	**Date:**
_________________________	_________________________	______________