DENTAL EMERGENCY
CLINIC

COVID-19 Screening & Consent

Patient name: _____ Temperature _____°C

1.	Do you have COVID-19 or had close contact with a confirmed case of COVID-19?	Yes	No
2.	Have you been in close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	Yes	No
3.	Do you have any of the following symptoms: • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Difficulty breathing • Sore throat • Difficulty swallowing • Decrease or loss of taste or smell • Chills • Headaches • Unexplained fatigue/malaise/muscle aches (myalgias) • Nausea/vomiting, diarrhea, abdominal pain • Pink eye (conjunctivitis)' • Runny nose/nasal congestion without other known cause •	Yes	No
4.	If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increase number of falls, acute functional decline, or worsening of chronic conditions	Yes	No

Although there is a risk for the spread of COVID-19, we are taking every recommended measure to prevent its spread during your visit.

I acknowledge my answers are true, I understand the risk, and consent to treatment.

Signature: _____ Date: _____

641 Davis Dr., Unit 100, Newmarket, ON L3Y 2R2
Tel: 905.252.5555 **Fax:** 905.252.2075 info@dentalemergency.ca DentalEmergency.ca