[Insert practice logo here]

Consent to dental treatment during COVID-19

I am aware that the current COVID-19 pandemic brings a number of known risks and a number of unknown risks. I have chosen to seek dental treatment during the pandemic in the knowledge that much is still unknown about the virus.

I understand the coronavirus that causes COVID-19 has a long incubation period during which time carriers of the virus may not show symptoms yet still be highly infectious. I also understand that some people may have the virus but may not ever have any symptoms. I therefore understand it is impossible to determine who has the virus and I understand that I must assume that anyone anywhere could be infected and infectious _____ Initial

I confirm that I am not currently suffering from any of the following symptoms of Covid-19 and I have not suffered from any of these symptoms in the last 7 days _____ Initial

- Fever (a temperature of 37.8 degrees centigrade or above).
- A new persistent dry cough.
- Muscle pains.
- Headache.
- Shortness of breath and breathing difficulties.
- Severe pneumonia.
- Loss of taste and/or smell.
- Extreme fatigue.
- Runny nose.
- Sore throat

I confirm that I have not been in close contact (within 2 metres) of anyone suffering with any of these symptoms in the last 14 days _____ Initial

I understand that receiving dental treatment means that the UK government's instruction to maintain social distancing of at least 2 metres is not achievable during treatment _____ Initial

[Insert practice logo here]

I understand that some people are considered to be at greater risk of serious illness or higher mortality if they contract COVID-19 and I understand that these are individuals who:

- Have pre-existing medical conditions such as heart and circulatory disease.
- Have high blood pressure.
- Have diabetes.
- Are very overweight.
- Are male.
- Are over 60 years of age.
- Are from a black, Asian or minority ethnic (BAME) background.

_____ Initial

I understand that Thornhill Dental Practice will take every precaution to make sure my treatment is provided according to strict clinical protocols and hygiene procedures _____ Initial

I consent to the treatment being provided during the current phase of Covid-19.

Name_____ Date_____

Signature _____