Patient name:_____

Date of Birth:_____

1. Do you have a fever or have felt hot or feverish in the last two weeks? **YES NO**
2. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post nasal-drip? **YES NO**
3. Have you experienced a recent loss of smell or taste? **YES NO**
4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19? **YES NO**
5. Have you returned from travel outside of Canada in the last 14 days? **YES NO**
6. Have you returned from travel within Canada from a location known affected with COVID-19? **YES NO**
7. Are you over the age of 70? **YES NO**
8. Do you have any of the following: Heart disease, lung disease, kidney disease, diabetes or any autoimmune disorder**? YES NO**
9. I understand that while Oak Bay Dental Centre and its staff have taken measures to minimize the risk of viral transmission, the nature of dental treatment means that physical distancing is not possible, and risk cannot be completely eliminated**. YES NO**
10. I understand that asymptomatic spreaders of the virus is an unavoidable risk of practice until there is either an effective treatment or vaccine against COVID-19 **YES NO**
11. I understand that it is possible that dental procedures can create water and/or blood spray, which may be 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**. YES NO**
12. I consent to receiving treatment despite some risk. **YES NO**

Patient signature: _____

Date: _____