Bharati Vidyapeeth
(Deemed to be University)
Dental College and Hospital, Pune.

COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

Name of patient: **Date:**

Age/Sex: **Case No.** **Mobile Number:**

Residential Address:

COVID-19 QUESTIONNAIRE	YES	NO
Do you have any symptoms of Fever, Dry Cough, Shortness Of Breath, Fatigue, Running Nose, Nasal Congestion, Sore Throat, Diarrhea, Headache, Sneezing, Chills, anytime during last 21 days? If yes, details		
Did you experience any difficulty in breathing anytime during last 21 days? If yes, details.		
Do you have any exposure to a known or suspected case of Covid-19 patient in last 21 days? If yes, details.		
Have you visited any other medical facility /hospital in last 21 days? If yes, for what reason?		
Are you residing in a locality that has been notified by the government as a covid containment zone in last 21 days?		
Is your workplace area in any containment zone notified by the government? If yes, details or Have you travelled to any containment zone area in the past 21 days		
Have you ever been tested for Covid-19? If yes, give details		

The above information given by me is true to the best of my knowledge. I fully understand and acknowledge that withholding or mis-representation of any information is highly unethical and against the interest of larger population during this pandemic.

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I have been made aware that dental procedures create ultra-fine water spray that may transmit the Covid-19 virus. I understand that the Covid-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. I also understand that, due to the contagious nature of the disease and characteristics of dental procedures, I have an increased risk of contracting the virus during dental treatment in the Dental Hospital/Institute/College in spite of the best disinfection protocols applied.

I fully understand and acknowledge that I may be an asymptomatic carrier of the disease. I therefore undertake to strictly comply with all safety precautions and protocols advised by the Government authorities and the Doctors of the Dental Hospital from time to time. In the eventuality of my testing covid positive at a later date, I will not hold the dental service provider/staff/Institute or anyone else responsible for it .I hereby knowingly and willingly give consent to have my emergency / urgent dental treatment completed during the Covid pandemic.

Signature/ thumb impression of patient with Date:

Name of Doctor:

Signature of Doctor with Date: