CONSENT TO DENTAL TREATMENT/EXAMINATION 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 contagious. 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.

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 and I understand that Bounty Road Dental Practice has taken every precaution to make sure my treatment is provided according to strict clinical protocols issued by NHS England .

Name …….. Signature ……..

Bounty Road Dental Practice

74 Bounty Road, Basingstoke, Hampshire, RG21 3BZ
Tel: 01256 465764

SELF DECLARATION BY VISITOR

1.	Have you tested positive for COVID-19? YES _____ NO_____
2.	Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? YES _____ NO_____
3.	Have you returned from abroad within last 14 days? Or Have you been in close contact with anyone who has travelled abroad within last 14 days. YES _____ NO_____
4.	Do you have a new continuous cough (1hr recurrently or 4+ episodes/24hr) or partial/total loss of your sense of smell or taste or any flu like symptoms (including sore throat, respiratory illness) in the last 14 days? YES _____ NO_____

If the answer is "YES" to any of the questions, access to the facility will be denied.

Name …….. Signature ……..

Date ……..