Consent to dental procedures during the COVID-19 pandemic

Dear patient,

This is a new Health & Safety Executive (www.hse.gov.uk) requirement for your safety and for the staff's safety and must be completed before attending the surgery.

I Have read, understand, and will abide by the following:

1. I am aware that the current COVID-19 pandemic brings a number of known risks and a number of unknown risks.

2. I have chosen to seek dental treatment during the pandemic and feel that this treatment I have booked for is an important part of maintenance or treatment of my dentition, this is to avoid further damage or any pain in the future.

3. **I understand that if I,** the patient, have any Symptoms of Covid19 or have been in close contact with someone who has: then I must call the practice immediately and inform them.

   These symptoms include (plus any other that the government may recommend):

   - Fever (a temperature of 37.8 degrees centigrade or above).
   - A new persistent dry cough.
   - Shortness of breath and breathing difficulties.
   - Loss of taste and/or smell.
   - Flu like symptoms

I confirm that I do not have any symptoms of Covid 19. ..... **Please sign here**

4. I confirm that I am **not** in a high risk category, including: those asked to shield by the government, patients with diabetes, cardiovascular disease, lung disease including moderate to severe asthma, being immune-compromised, having active malignancy, or over age 70. _____(Initial)

OR

I confirm that I fall into the following '**high risk'** category
(_____) _____ (Initial)

I understand the risks involved during a pandemic and I agree to proceed with dental care as advised

Signed ..... **date** .....

Please ensure that the form is signed before your appointment.

Medical History

Date		

Patient Name:	

Patient D.O.B.		Age =	Over 70? (Please tick)

Are you in good health?	Yes	No
Have you had any operations or serious illnesses in the past?	Yes	No
Are you currently attending a doctor, hospital clinic or Specialist?	Yes	No
Are you or could you be pregnant/	Yes	No

Do you have, or have had any problems with the following?

Breathing e.g. asthma, COPD, bronchitis shortness of breath or a persistent cough?	Yes	No
Heart e.g. heart attack, angina, murmur, a replacement valve or pacemaker, heart failure.	Yes	No
Blood pressure?	Yes	No
Blood e.g. anaemia, prolonged bleeding, bruising, sickle cell disease, thalassemia?	Yes	No
Stomach and gut e.g. ulcers, gastric reflux or colitis?	Yes	No
Kidneys, bladder or liver e.g. chronic infections, jaundice, or cirrhosis of the liver?	Yes	No

Medical History

Nervous system e.g. epilepsy, stroke, Parkinsons or multiple sclerosis?	Yes	No
Hormones e.g. diabetes or thyroid?	Yes	No
Joints and bones e.g. arthritis or osteoporosis?	Yes	No
Skin e.g. eczema or psoriasis?	Yes	No
Mental health e.g. anxiety, depression, schizophrenia, bipolar, eating disorders?	Yes	No
Allergies or reactions to drugs, latex, food or metals?	Yes	No
Have you ever had or are having treatment for cancer e.g. chemotherapy or radiotherapy?	Yes	No
Could you have contracted an infection such as hepatitis, HIV, TB or CJD?	Yes	No
Do you have a learning disability?	Yes	No
Do you have a physical disability e.g. wheelchair use, visual or hearing?	Yes	No
Have you ever had a bad reaction to general or local anaesthetic?	Yes	No
Do you have a yearly flu jab?	Yes	No
Is your BMI over 40	Yes	No

Are you taking any Medications or drugs which are prescribed, bought over the counter?	Yes – please list below	No

Medical History

Medication	Dose

Do you smoke, vape, use shisha or chew pan?	Yes – how much?	No
Do you drink alcohol?	Yes _ how many units per week? 1 unit = ½ pint beer, small glass of wine, single measure of spirits	No

Name:	Signature:	Date: