



COSMODENTAL

**COVID-19 TREATMENT CONSENT FORM**

I, \_\_\_\_\_, consent to have dental treatment during the COVID-19 pandemic at this office. I have also been verbally informed of the risks.

- I confirm that I am not presenting with any of the following symptoms of COVID-19 listed below:

- |             |                               |
|-------------|-------------------------------|
| Fever       | Shortness of Breath           |
| Dry Cough   | Runny Nose                    |
| Sore Throat | Sudden loss of taste or smell |

\_\_\_\_\_ **(Initial)**

- I verify that I have not traveled outside the Philippines in the past 14 days. And that I have been following the self- quarantine and social distancing guidelines for the past 14 days minimum. I also have not been exposed to a CORONAVIRUS positive patient in the last 14 days, to the best of my knowledge. \_\_\_\_\_ **(Initial)**

I understand that this office screens all patients and staff for possible COVID-19 infection per the current guidelines. However, carriers of the virus may be completely asymptomatic and still be contagious. Some may never develop full blown symptoms. Presently, it is impossible to determine who is an asymptomatic carrier. While this office strictly adheres to the DOH/PDA standards as they currently exist, Coronavirus is a new, highly contagious pathogen that can be transmitted to and from healthcare workers even under strictly followed DOH/PDA standards. This virus can be spread through **droplets or contact**. Additionally, certain Dental procedures create water mist (aerosol) which is one way the virus is spread. The aerosol and thus the virus can linger in the air for hours after certain dental procedures.

- I understand that due to other dental patients visiting the office and due to the characteristics of the virus and dental procedures, I have an elevated risk of contracting the virus simply by being in a dental office. \_\_\_\_\_ **(Initial)**
- I have been made aware of the DOH and PDA guidelines that under the current pandemic all dental visits should be limited to the treatment of pain, infection or conditions that significantly impair normal function of teeth and mouth. \_\_\_\_\_ **(Initial)**
- I confirm I am seeking treatment for a condition that meets these criteria. \_\_\_\_\_ **(Initial)**
- I understand the DOH recommends social distancing of at least 6 feet, and this is not possible when seeking dental care. \_\_\_\_\_ **(Initial)**

Signature\_\_\_\_\_

Date\_\_\_\_\_

# PATIENT SCREENING FORM

PATIENT NAME: \_\_\_\_\_

	PRE-APPOINTMENT	IN-OFFICE
Do you / they have fever or have you/ they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you / they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a cough?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you / they experienced recent loss of taste or smell?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you / they in contact with any confirmed COVID-19 positive patients? <i>Patients are well but who have a sick family at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your/their age over 60?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you/they travelled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

**Please be informed that upon arriving the office, these questions will be repeated and your temperature will be taken in order to ensure nothing has changed.**

**Please limit extra companions on your trip to the office to only essential people in order to reduce the number of people in the reception area.**



17<sup>TH</sup> CONGRESS  
3<sup>RD</sup> REGULAR SESSION  
REPUBLIC ACT NO. 113322

## **“MANDATORY REPORTING OF NOTIFIABLE DISEASES AND HEALTH EVENTS OF PUBLIC HEALTH CONCERN ACT”**

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Any person found to have violated this Act shall be penalized with a fine of not less than Twenty thousand pesos (P20,000.00) but not more than fifty thousand pesos (P50,000.00) or imprisonment up to six (6) months, or both such fine and imprisonment.

We would like to stress how important it is for you to disclose all possible health related information. We at Cosmo Dental would like to ensure maintenance of relevant, efficient, and effective disease surveillance and response system at the national and local levels.

Unauthorized disclosure of your private and confidential information pertaining to your medical condition or treatment is strictly prohibited.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_