



**MEDICAL & COVID SCREENING & CONSENT**

(Please send completed form to [formreturns@ashforddentists.com](mailto:formreturns@ashforddentists.com) )

As part of our risk assessment, these medical history and COVID-19 screening questions are asked in line with the case definition for possible COVID-19 and isolation requirements.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ Date of birth \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMAIL: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

**COVID 19 SCREENING**

- Do you or anyone in your household have COVID-19?

YES / NO

- Do you have a new, continuous cough?

YES / NO

- Do you have a high temperature (37.8C or over)?

YES / NO

- Do you have a loss of, or change in, your normal sense of taste or smell?

YES / NO

- Does anyone in your household have a new, continuous cough, or a high temperature, or a loss of, or change in, their normal sense of taste or smell?

YES / NO

- If you or anyone in your household has, or has had, possible or confirmed COVID-19, are you still in the self/household isolation period?

YES / NO

**MEDICAL HISTORY**

- Are you taking any regular medication currently including pain relief?

YES / NO If so please give details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Do you have any heart or blood pressure problems?

YES / NO If so please give details here:

- Do you have diabetes?

YES / NO If yes how is it controlled?

- Do you suffer with epilepsy or periods of altered consciousness?

YES / NO

- Do you have any conditions affecting your breathing such as asthma or COPD?

YES / NO If yes please give details here:

- Are you allergic to any medicines or any other substances?

YES ? NO If yes please give details here:

- Could you be pregnant?

YES / NO If yes please give estimated due date:

- Have you had any form of recent surgery or major surgery in the past?

YES / NO If yes please give details here:

- Do you have any anxiety issues related to dental surgery?

YES / NO If yes please give details here:

- Have you had any major dental work in the past?

YES / NO Please give details here :

## Consent to dental treatment 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 consent to the treatment being provided during the current lockdown phase of Covid-19

Signature

Date

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