Indian Dental Association
Kerala State Branch

COVID 19
INFORMED CONSENT FOR DENTAL TREATMENT

Name : ---------- Age/Sex: : ---------- **M / F**

Occupation : ---------- Mobile No: : ----------

Address: : ---------- Date / Time : ----------

	COVID 19 - QUESTIONNAIRE	YES	NO
1	Have you or any of your cohabitants been diagnosed with Covid-19 ?		
2	Have you or any of your cohabitants been under quarantine as instructed by the Kerala state health dept?		
3	Do you have any symptoms like fever, body pain, cough, sneezing, sore throat, difficulty in breathing?		
4	Have you visited a general physician if your answer is 'yes' for the above question?		
5	Have you or any of your cohabitants travelled outside country/state in the past 45 days ?		
6	Any of your family members have history of fever, body pain, cough,		
7	sneezing, sore throat, difficulty in breathing ?		
8	Do you have any medical issues ?(if yes, mention the details)		
9	Do you belong to Covid-19 sensitive area (hot-spots) or have visited one such place in last 45 days ?		
10	Have you recently participated in any gathering, meetings, or had close contact with many unacqainted people ?		

I ---------- have come to this Dental Clinic/Hospital for dental treatment. The doctor reserves the right to Treat / Defer / Refer me accordingly.

If I happen to be an asymptomatic carrier or an undiagnosed patient with Covid-19 disease, I suspect it may danger the doctors and other clinic staff. It is my duty and responsibility to take appropriate precautions and follow the protocols prescribed by them. I also know and understand that I may already be an asymptomatic carrier / undiagnosed COVID-19 positive patient / may get infected due course of time after my visit to the dental clinic and I will not hold the doctors or the staff of the clinic responsible for any future diagnosis of COVID-19 with me or my accompanying person.

The above terms and conditions have been read by me/have been explained to me in my native language to my complete satisfaction. I agree to all terms and conditions mentioned above. I verify, confirm and agree to be held accountable, regarding the details given by me which I state are true to the best of my knowledge.

Signature of Patient / Parent / Guardian	
Signature of Accompanying person	

Name of the Dentist & Signature :

KDC Reg.No:

N.B. Not disclosing information or providing false information is a punishable offence under the IPC and Kerala Epidemic Diseases Ordinance 2020.