Estd. MCMXCVII

Dr Lall's Dental Specialties

6, Sainik Vihar, Pitampura, New Delhi 110034
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CONSENT FORM FOR PROCEDURE, TREATMENT &ANAESTHESIADURING COVID 19 PANDEMIC

Instructions: This consent form should be signed by you if you are an adult (18 years or older), by a parent or guardian if the patient is a minor; by the spouse or adult children or parents or adult brothers or sisters or other family members or significant other (in this order of priority) if the patient lacks the ability to make an informed decision.

1. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

2. If I am an asymptomatic carrier or an undiagnosed patient with COVID 19, I suspect it may endanger doctors and clinic staff. It is my responsibility to take appropriate precautions and to follow the protocols prescribed by them.

3. I am aware that I may get an infection from the clinic or from a doctor, and I will take every precaution to prevent this from happening, but I will not at all hold doctors and clinic staff accountable if such infection occurs to me or my accompanying persons.

4. In case I or my attendant get the COVID 19 infection after the visit to the clinic, I will inform the clinic authorities at the earliest, so that appropriate tracking of the patients/attendants and clinic staff present on the day of my visit can be done.

5. I confirm that I and / or my attendant am not presenting any of the following symptoms of COVID-19 listed below:

a -Fever
b -Shortness of Breath
c -Loss of Sense of Taste or Smell
d -Dry Cough
e -Runny Nose
f -Sore Throat

Initials of the Patient / Patient's Representative _____

6. I understand the Government recommends social distancing of at least 6 feet for a period of 14 days to anyone who has shown symptoms or tested positive.

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7. I verify that I have not travelled outside of India in the past 14 days to countries that have been affected by COVID-19.

8. I verify that I have not travelled domestic within India by commercial airline, bus, or train within the past 14 days.

9. I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to treatment completed during the COVID-19 pandemic. If I hide my facts and relevant details and because of my knowing or unknowing behaviour or action the clinic staff gets infected, I may be held responsible for appropriate compensation in the Court of Law.

AUTHORIZATION OF PATIENT / PATIENT'S REPRESENTATIVE

I, _____ acknowledge that I have had an opportunity to discuss the above mentioned, with my Doctor or Doctor Designee.I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

Patient's Signatures: _____Date: __/__/20__ Name _____

Witness's Signatures: _____Date: __/__/20__ Name _____

Doctor's Signatures: _____Date: __/__/20__ Name _____

The patient is unable of consent because_____

And I, _____, therefore consent for the patient.

Please state Name and Relationship with the Patient

I acknowledge that I have had an opportunity to discuss with the doctor or doctor designee and herby consent to the procedure for the patient _____.

Patient's Representative Signatures: _____ Date: _ _/_ _/20_ _

Patient'sRepresentative Name: _____

Witness's Signatures: _____Date:_ _/_ _/20_ _Name _____

Doctor's Signatures: _____Date: _ _/_ _/20_ _ Name _____