COVID-19 Treatment Consent Form

I, ______________________________ (Patient or Parent/Guardian), knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

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.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.
- I understand that this dental office is taking additional steps to comply with government mandates and protect safety of both patients and staff during the COVID-19 pandemic.

I confirm that I am not presenting any of the following COVID-19 symptoms: ___________ (Initial):

- Flu-like symptoms such as fever and chills, gastrointestinal upset, headache or fatigue
- Shortness of Breath
- Dry Cough
- Runny Nose
- Muscle Pain
- Sore Throat
- New Loss of Taste or Smell

The CDC recommends social distancing of at least 6 feet from others. I understand this is not possible with dentistry.

- I verify that I have not traveled outside the United States in the past 14 days. I also verify I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. __________(Initial)
- I verify I have not been in contact with any confirmed COVID-19 patients in the past 21 days. __________(Initial)
- I understand that the doctor and office staff have answered all my questions regarding COVID-19, as well as the increased infection control standards the office has *implemented* to keep everyone safe as possible.

Patient Name: ____________________________________ Date: ______________

Patient/Guardian Signature: __________________________