COVID-19 Pandemic Dental Treatment Consent Form

Patient Name: _____ DOB: _____

I certify that I am the Patient/guardian of _____. I knowingly and willingly consent to have dental treatment completed on myself or minor child, 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 give the current limits in virus testing.

Dental procedures create water spray which is thought to be a primary way for the disease to 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 I cannot wear a protective mask over my mouth to prevent infection during treatment as my health care providers need access to my mouth to render care. This leaves me vulnerable to COVID-19 transmission while receiving dental treatment.

_____ (initial) I understand that due to the visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I and myself have an elevated risk of contracting the virus simply by being in a dental office.

_____ (initial) A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy and any prior or current disease or medical condition) can put me at greater risk for contracting COVID-19. I have disclosed any condition that compromises my immune system and understand that I may be asked to consider rescheduling treatment after discussing any such conditions with the provider.

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

○ **Shortness of Breath** ○ **Dry cough** ○ **Fever** ○ **Runny Nose** ○ **Sore Throat** _____ (Initial)

_____ (Initial) The CDC recommends social distancing of at least 6 feet which is not possible with dentistry.

_____ (Initial) I verify that Patient/I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19.

_____ (Initial) I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. I understand that air travel significantly increases the risk of contracting and transmitting the COVID-19 virus.

By signing below in both my individual capacity and as Patient/Guardian, if applicable, I represent that I have fully read and understood the provisions above, have had the opportunity to ask questions about any of the above, and that I accept the associated risk to myself and to minor Patient (if applicable), and do hereby authorize the treatment prescribed.

_____ Date: _____
Signature Patient/Guardian

_____ Date: _____
Print name Patient/Guardian