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COVID-19 Pandemic Dental Treatment Consent Form

Dear Patient:

You have presented to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.
- I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and may still be highly contagious. It is impossible to determine who does and does not have it given the current limitations in virus testing.
- I understand that the CDC recommends social distancing of at least 6 feet and this is not possible with dentistry.

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

Are you awaiting the results of a COVID-19 test?	○ Yes	○ No
Have you had contact with any confirmed COVID-19 positive patients?	○ Yes	○ No
Have you had a fever recently?	○ Yes	○ No
Have you had shortness of breath or difficulties breathing?	○ Yes	○ No
Do you have a cough?	○ Yes	○ No
Do you have other flu-like symptoms, such as gastrointestinal upset, diarrhea, headache or fatigue?	○ Yes	○ No
Have you travelled to any foreign country or any regions affected by COVID-19 in the last 14 days?	○ Yes	○ No

IF SO, WHERE? _____

_____ _____
PATIENT/RESPONSIBLE PARTY DATE

_____
PATIENT NAME

2935 E. 96th Street, Suite 100

WHICH LOCATION WILL YOU BE VISITING