COVID-19 Dental Consent Form

I, _____, consent to have dental treatment completed during the COVID-19 pandemic at this office. I have also been verbally informed of the risks.

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

Fever Shortness of Breath Dry Cough Runny Nose
Sore Throat Sudden loss of taste or smell

- I verify that I have not been exposed to a CORONAVIRUS positive patient in the last 14 days to the best of my knowledge.

I understand that this office screens all patients and staff for possible COVID-19 infection per the current guidelines. **However, carriers of the virus may be completely asymptomatic and still be contagious.** Some may never develop full blown symptoms. Presently, it is impossible to determine who is an asymptomatic carrier.

While this office strictly adheres to the OSHA/CDC standards as they currently exist, Coronavirus is a new, highly contagious pathogen that can be transmitted to and from healthcare workers even under strictly followed OSHA/CDC standards. This virus can be spread through droplets or contact. Additionally, certain Dental procedures create water mist (aerosol) which is one way the virus can be spread. The aerosol and thus the virus can linger in the air after certain dental procedures. **Our office has taken extra precautions and implemented additional safety protocols during this time to help minimize the risk, however, it is not possible to completely eliminate the risk altogether.**

- I understand that there might be an elevated risk of contracting Covid-19 in a dental setting due to the nature of dental procedures.
- I understand the CDC recommends social distancing of at least 6 feet, and this is not possible when seeking dental care.

If, at any point in the next 14 days, I begin to exhibit symptoms of the COVID-19 virus, I will inform the practice immediately and will inform them of any testing results or quarantine orders I receive from a medical physician. I understand this continued communication with the practice is essential to help curb the spread of the virus and to allow the practice to provide informed consent to other patients and to otherwise take protective measures. I understand the practice will not share or disseminate any of my protected health information for any unlawful or prohibited purpose. _____(initial)

Patient/ Parent or Guardian Signature_____Date: _____