COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I, _____(Patient Name), the undersigned, after a full discussion with and disclosures made by my dentist and his/her office staff, knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

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

____ I understand that:

- Dental procedures create water spray which is how the disease spread.
  - Ultrafine nature of the spray can linger in the air or minutes to sometimes hours, which can transmit the COVID-19 virus.
  - Due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, I have an elevated risk of contracting the virus simply by being in a dental office.

_____ I have been made aware of the CDC and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended, and any dental treatment should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth in mouth, and issues that may cause anything listed above within the next three to six months.

_____ I confirm I am seeking treatment for a condition that meets these criteria.

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

- Fever
- Shortness of breath
- Runny nose
- Sore throat
- Other_____.

____ I understand that significant travel increases my risk of contraction and transmitting the COVID-19 virus, and that the CDC recommends social distancing, at lease six feet for a period of 14 days to anyone who has, and I understand that this in not possible with dentistry.

____ I verify that I have not traveled outside the United States by commercial airline, bus, or train within the past 14 days.

____ I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19

_____ In the interest of public health and for the benefit of my dentist and his/her office staff, to the best of my ability but without liability for failure to do so , I agree to inform the dental office if I am subsequently diagnosed, or if I come in contact with another person having been diagnosed, with he virus, so that my dentist and his/her office staff may act accordingly.

Name_____ Date_____