

COVID 19 Consent Form

I, _____, knowingly and willingly consent to have dental treatment completed.

Procedure Issues

_____ After my procedure, I understand that I may be at a higher risk for further infection and agree to remain at home, in compliance with the state mandates.

_____ I understand that to mitigate these risks, it is imperative that I take the medications as prescribed. I further understand that certain medications, such as opioid “pain” medications, cannot be called into pharmacies.

Unique Circumstances

_____ Dental procedures create water spray (aerosol), 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 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.

_____ 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 by being in a dental office.

_____ I confirm that I do not have any of the following symptoms of COVID-19: fever, shortness of breath, dry cough, runny nose, sore throat currently, or for the last 14 days.

_____ I confirm that I have not, within the past 14 days, traveled by airplane, been at a gathering of 10 or more persons, and have not traveled outside my usual commute.

_____ I confirm that I have not been in contact with a person that has been diagnosed with COVID- 19 within the last 14 days.

_____ I understand that the CDC recommends social distancing of at least 6 feet to prevent transmission of disease and this is not possible with dentistry.

_____ I agree that, if I were to exhibit any symptoms of, or am diagnosed with, COVID-19, I will immediately contact my dentist so that proper steps can be taken to limit the spread of this contagion.

_____ I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be completely successful in resolving my pain and/or infection. It is anticipated that the treatment will provide benefit in reducing the cause of this condition. However, due to individual patient differences and the extenuating circumstances, there exists a risk of failure relapse, selective re-treatment, or worsening of my present condition, including the loss of additional teeth/bone, despite the best care.

I have read, comprehend, and agree with the above statements. I consent to the performance of the treatment proposed by my dentist.

Name _____

Date _____

For office use only

Patient temperature: Temp: _____ Time: _____

Patient breath test: Pass: _____ Fail: _____

Pulse oximetry O2: _____ HR: _____

The following patient is currently cleared for treatment: _____

The following patient is not currently cleared for treatment: _____