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COVID-19 Pandemic Dental Treatment Consent Form

I,_____(print name), knowingly and willingly consent to having dental treatment completed 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. Given the current limits in virus testing, it is impossible to determine who has it and who does not have COVID-19. _____(Initial)

Dental procedures create water spray (aerosols), which is one way the disease can be spread. The ultra-fine nature of the spray can linger in the air for several minutes to hours, which can transmit the COVID-19 virus.

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 simply by being in a dental office. _____(Initial)

I have been made aware of the Centers for Disease Control and Prevention (CDC) and American Dental Association (ADA) guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above during the next 3-6 months. I confirm I am seeking treatment for a condition that meets these criteria _____(Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 nor in the last 14 days, have I been in contact or associated with some who has, the following symptoms:

- New loss of taste or smell
- Red spots on toes
- Cough
- Fever
- Muscle pain
- Shortness of breath or difficulty breathing
- Unexplained rash
- Nausea or diarrhea
- Sore throat
- Chills
- Feeling very tired

_____(Initial)

I confirm that I have not been in contact or have experienced any of the following, which are emergency warning signs for COVID-19:

- Trouble breathing
- New confusion
- Bluish lips or face
- Persistent pain or pressure in the chest
- Inability to wake or stay awake

_____(Initial)

I understand that air travel significantly increases the risk of contracting and transmitting the COVID- 19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days around anyone who has traveled by air, and this distance is not possible with dentistry.

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

I verify that I have not traveled within the United States by commercial airline, bus, or train within the past 14 days. _____(Initial)

Signature:_____Date:_____