COVID-19 Patient Waiver and Consent

I, ____, knowingly and willingly consent to receive dental treatment 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. It is impossible to determine who has it and who does not give the current limits in virus testing.

Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus.

I understand the CDC recommends social distancing of at least 6 feet to any individual not living in your household, but it is not possible with dentistry. ______ (Initial)

I confirm that if I am tested positive or presumptive positive by a medical professional within 14 days of receiving treatment, I will notify the practice immediately. _____(Initial)

____ I confirm that I am not or have not experienced any of the following symptoms in the last 14 days

- Fever (including low grade fever), fatigue, body aches recently (14-21 days)
- Dry Cough
- Sore Throat
- Shortness of Breath, Trouble breathing, Bluish lips or face
- Body Aches
- Chills, Repeated shaking with chills
- Muscle pain
- Headaches
- Loss of taste or smell
- Runny nose
- Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

__________(Initial)

I confirm that I have not traveled on a cruise ship in the past 14 days.________________________________(Initial)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days._____________________________________(Initial)

Patient Name ____ Relationship ________________________

Patient/Guardian Signature ____ Date______________________