DULLES
LIFE SMILES

COVID-19 Dental Treatment Consent Form

I, (the patient), consent to receive dental treatment from Dulles Life Smiles during the COVID-19 outbreak.

While our office complies with the State Health Department and the Centers of Disease Control and Prevention infection control guidelines to prevent spread of the SARS-COV-2 virus, we cannot make any guarantees.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

I understand that the symptoms listed below are representative of COVID-19:
- Fever (a temperature greater than 100.4 F or 38.0 C)
- Dry Cough
- Shortness of Breath or difficulty breathing
- Sore throat
- Persistent pain or pressure in the chest
- Bluish lips or face

In order to reduce the risk of spreading SARS-COV-2, for the safety of our staff, other patients, and yourself. we have asked you complete the “screening” section below.

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above: (Initial) _____

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) 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:_____

Patient/Guardian
Signature:_____Date:_____