Dental Treatment Consent and Affirmation Form
COVID-19 Reopening **TEMP_____**

I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:

Fever of 100.4 degrees Fahrenheit or higher
Cough
Shortness of breath
Difficulty breathing
Fatigue
Headache
New loss of taste or smell
Sore throat
Congestion or runny nose
Muscle or body aches
Nausea or vomiting and diarrhea

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I confirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in the last 14 days. I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

_____ _____
Patient's name (please print) Signature of patient, legal guardian or authorized representative

_____
Date