COVID-19 Treatment Consent Form

I, _____, consent to receive treatment from Four States Dental Care during the COVID-19 outbreak. I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmits.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

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

I understand that due to the unknowns of this virus, the number of patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and receiving treatment in the practice.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID-19, which are outlined above: ( )

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission in the past 14 days. ( )

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. ( )

Patient Name: _____

Patient/Guardian Signature: _____ Date:_____