COVID-19 Dental Treatment Consent Form

You are receiving dental care during the pandemic events of COVID-19 national emergency. Please be advised that there may be increased risk of exposure from doctors, staff, other patients, and the treatment facility. We are taking precautions to limit the spread of this disease, but there is still a possibility of transmission.

Dental Treatment Consent

1. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I do hereby acknowledge the health risks of the COVID-19 virus during this national emergency and I willfully request and authorize the doctors and staff at **Dental Day LLC** to perform any necessary dental and/or orthodontic services. I will be responsible for any charges incurred for my treatment.

2. 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 given the current limits in virus testing.

3. 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.

4. I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below:

    - Fever
    - Shortness of Breath
    - Loss of Sense of Taste or Smell
    - Dry Cough
    - Runny Nose
    - Sore Throat
    - _____(**initials)**

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

    _____(**initials)**

6. I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19.

    _____(**initials)**

7. I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

    _____(**initials)**

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE