COVID-19 Pandemic Dental Treatment Consent

RC dental care
Albert Lee, D.D.S., & Associates

1. Name: _____ (Last Name) _____ (Initial) _____ (First Name)
2. Date of Birth: _____ (MM) _____ (DD) _____ (YY)
3. Initial Below:

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. Dental procedures create water stray which is how the disease is spread. The ultra fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

_____ Initial

4.Despite our careful attention to sterilization, disinfection, and use of person barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient , dentist, staff and sometimes other patients at all times. Although unlikely, I accept the risk and consent to treatment?

_____ Initial

5. I understand that due to the frequency of the visits of other dental patients, the characteristics of the virus, and the characteristics of the dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.

_____ Initial

6. I confirm that I and/or my child or others accompanying me to today's appointment are not presenting any of the following symptoms of COVID-19 listed below:

- *Fever (defined as above 99.6 degrees)*
- *Shortness of breath or trouble breathing*
- *Dry Cough, Runny Nose, Sore Throat*
- *Persistent pain, pressure, or tightness in the chest*

_____ Initial

6. I confirm that I and/or my child or others accompanying me to today's appointment or anyone I have recently been in contact with have not tested positive for or have been diagnosed as having the COVID-19 or any other communicable disease. I understand that if I am not able to confirm the aforementioned, I may

Signature of Patient or Parent/Guardian	*If Parent/Guardian Print Name*	*Date of Signature*