COVID-19 Pandemic Dental Treatment Consent Form

I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

Furthermore, I understand, recognize, and acknowledge the following:

- ***Regarding the risks of contracting COVID-19 as a result of coming in the dental office and undergoing dental treatment:***
  - The medical community is still learning about the transmission process of COVID -19 and recommendations are continually being modified.
  - The virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is therefore impossible to fully determine who has it (including both dental patients and dental staff) and who does not, given the current limits in virus testing.
  - 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.
  - Due to the nature of dentistry, it is not possible to maintain social distancing during dental treatment.
  - The dental office is taking extensive measures to increase the safety of each patient. Additionally, I am free to ask details about these precautions.
  - In spite of all good faith attempts to identify dental patients and dental staff members who may be infected, it is possible that either could be contagious and not yet show symptoms.
  - ***I recognize that, in spite of all precautions being taken by the dental office and team, I run the risk of contracting COVID-19 as a result of being in the dental office and/or undergoing dental treatment.***
    ____________ ***(initial)***

- ***Regarding my current health and possibility of being contagious,*** **neither I, nor any member of my household, nor anyone with whom I have knowingly come into contact have:**
  - Had any symptoms, within the past 14 days, of COVID-19 including, but not limited to: fever, headache, chills, shortness of breath, loss of sense of taste or smell, dry cough, runny nose, sore throat, etc.
  - Traveled outside the state or country, or have been in Blaine County within the past 14 days.
  - ***Based upon the questions above, and in addition to any other risks of infection of which I am aware, I have disclosed all information to my dentist and dental office and believe I am virus free.***
    ______________ ***(initial)***

- **I must notify the dental office if I become ill or I am diagnosed with COVID-19 within 7 days following my dental appointment.** ______________ ***(initial)***

- ***In order to help offset the significant increase in mandatory costs for supplies to keep me and my family safe from COVID-19, a per-visit charge will be added to my visit. This will be identified by code D1999. I understand that many insurances plans will cover this cost (at their contracted rate), but if not, I will be responsible for it ($15 non-insurance cash rate)*** ______________ ***(initial)***

Name:____________________________________ Signature: ______________________________ Date: __________

Witness:__________________________________ Signature: ______________________________ Date: __________