COVID-19 Treatment Consent Form

*Required
*Cell phone #_____ *Email _____

I,_____(the patient), consent to receive treatment from Maxson Dental P.C. during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and is transmitted.

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 other 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 by 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 COFID-19 can be spread.

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

- Fever
- Dry cough
- Shortness of breath
- Temperature
- 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: _____(Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival. _____(Initial)

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____(Initial)

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. _____(Initial)

Please circle your answer

Do you have fever or have you felt hot or feverish recently? (Within the last 2-3 weeks)
Yes No

Are you having shortness of breath or other difficulties breathing?
Yes No

Do you have a cough?
Yes No

Any other flu-like symptoms such as gastrointestinal upset, headache, or fatigue?
Yes No

Have you experienced recent loss of taste or smell?
Yes No

Are you in contact with confirmed COVID-19 positive patients?
Yes No

Is your age over 60?
Yes No

Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?
Yes No

Have you traveled in the past 14 days to any regions affected by COVID-19 (as relevant to your location)?
Yes No

Patient Name: _____

Patient/Guardian Signature: _____
Date:_____

Any changes to your dental insurance? If yes:
Subscriber's full name: _____Subscriber's DOB:_____
Employer:_____Ins. Company: _____
Member ID #: _____ Group #:_____

Any changes to your mailing address? If yes, please provide:_____

For Practice Use:
Doctor Signature: _____
Date:_____