COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I, _____ (Print name), knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand that 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 spray one way 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.

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

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

-Fever

-Shortness of breath

-Dry cough

-Runny nose

-Sore throat

_____ (Initial)

I understand that the CDC recommends social distancing of at least 6 feet and that this is not possible in dentistry.

_____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus.

-I verify that I have not traveled outside the United States in the last 14 days _____ (Initial)

-I verify that I have not travelled via airline, bus, or train within the last 14 days _____ (Initial)

I have discussed with my dentist the pros and cons of my dental treatment in relation to contracting COVID-19.

I am satisfied that my dentist answered all of my questions.

Although there are no guarantees in regards to the possibility of contracting COVID-19, my dentist and his staff will be following safety protocols as to best protect myself and the staff during treatment. I understand that I have the possibility to delay my treatment, and I have elected to have the procedure at this time.

Signature: _____ Date: _____

Temperature (taken in office): _____ Time taken: _____

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.