COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

Patient Full Name:_____ DOB:_____
Address:_____

City:_____State: _____Zip:_____

Telephone Number:_____

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.

_____ (Initial)

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

-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.

-Fever

-Shortness of breath, tight feeling in chest

-Dry cough

-Runny nose

-Sore throat

-Recent loss of taste or smell

_____ (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 her 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 treatment at this time and all future appointments for the duration of the COVID-19 Pandemic.

Signature: _____ Date: _____

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

Staff Member Intials:_____

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the SARS-COV-2 Pandemic

Dear Patient:

You have presented to the office today for dental treatment. While our office complies with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the SARS-COV-2 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading SARS-COV-2, we have asked you several "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

_____ _____

Patient/Responsible Party Date

Please answer "Yes" or "No" with your initials, to the following questions:

Do you have a fever? _____Yes _____No

Do you have any shortness of breath? _____Yes _____No

Do you have a dry cough? _____Yes _____No

Do you have any other flu-like symptoms? _____Yes _____No

Have you experienced recent loss of taste or smell? _____Yes _____No

Contact with any confirmed COVID-19 positive people? _____Yes _____No

Within the last 14 days:

Have you travelled to any foreign country? _____Yes _____No

Have you travelled within the US? _____Yes _____No

If so, where?_____

Credit Card on File Authorization

For contact-less payment I authorize Mary E. Gregory D.D.S. to keep my credit card on file for payment. If you elect to change the method of payment, please let us know. Otherwise the card provided will be charged.

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover ❑ Care Credit

Expiration Date: _____

Security Code: _____ (3 digit code on back)

Billing Address: _____

E-mail: _____

I, _____, authorize ***Mary E. Gregory D.D.S.***, to charge the above credit card account for payments owed to my account. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature: _____ Date:_____