Angel Smiles Pediatric Dentistry

COVID-19 Pandemic
Dental Treatment Consent Form

Patient Name:

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to hours, which can transmit the novel coronavirus.____________(Initial)

I understand that due to the frequency of visits of other team members, dentist and dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office. _______ (initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by state Health Services:

- Fever > 38 C/100.4 F ______________(initial)
- Cough _____________(initial)
- Sore Throat ____________(initial)
- Shortness of breath __________(Initial)
- Flu-like symptoms _________(Initial)
- Lost smell or taste _________(initial)

I confirm that I have considered if I am in high risk category (e.g. diabetes, heart disease, lung diseases, >60 years of age) and have chosen to have dental treatment. _________(initial)

I confirm that I am not currently positive for the novel coronavirus. _________(initial)

I confirm that I am not waiting for results of a laboratory test for novel coronavirus_____(initial)

Angel Smiles Pediatric Dentistry

COVID-19 Pandemic
Dental Treatment Consent Form

I verify that I have not returned to states from any country outside of U.S. or other states whether by car, air, bus or train in the past 14 days. ___________(Initial)

I understand that any travel from any country outside of U.S. including travel by car, air, bus or train, significantly increases my risk of contracting and transmitting the novel coronavirus. State Health Services require self-isolation for 14 days from the date a person has returned to U.S.____________(Initial)

I understand that state Health Services has asked individuals to maintain social distancing at least 2 meters (6 feet) and it is not possible to maintain this distance and provide or assist with dental treatment. ____________(Initial)

I verify that I have not been identified as a close contact a confirmed case of someone who has tested positive for novel coronavirus and/or been asked to self-isolate by state Health, the Communicable Disease Control or any other governmental health agency.___________(initial)

____

List of Dental Treatment

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above listed emergency dental treatment completed during the COVID-19 pandemic.

____
Signature of Patient

Printed
Name_______________________________________Date___________________________