Patient Request for Treatment, Representations and Consent

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office and the patients, staff and other individuals who come upon the premises. _____ (Initial here)

Accordingly, as a precondition to rendering treatment, I confirm I have no symptoms commonly associated with COVID-19, including fever, shortness of breath, dry cough, running nose or sore throat and that I have not within the past 14 days had close contact with a person who has confirmed positive or suspected to be positive for COVID-19. _____ (Initial here)

You are receiving dental care during the events of a COVID-19 National Emergency. Please be advised that there may be risks in being in the proximity of dentists, patients, or staff. We are taking precautions to limit the spread of disease, yet there is still a possibility of transmission. I accept this risk. _____ (Initial here)

Name: _____

Signature: _____

Date: _____

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