

**COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM**

Our goal is to always provide a safe environment for our patients and staff, and to advance the safety and wellbeing of our local community. This document provides information we ask you to read and acknowledge regarding the COVID-19 virus and your dental care.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. The COVID-19 virus has a long incubation period and a person may have the virus, may not show symptoms and yet may be contagious. Determining who is infected by COVID-19 is challenging due to limited availability for widespread virus testing. Our practice wants to ensure that you are aware of the risks of contracting COVID-19 that are associated with dental care. Although we are consistently following screening, sanitization, and infection control practices that meet or exceed Centers for Disease Control (CDC) and state public health guidelines, and our dental professionals are using personal protective equipment recommended by the American Dental Association (ADA) and others, social distancing is not always possible while providing dental care.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer, radiation treatments, chemotherapy, and other prior or current diseases or medical conditions), can put you at greater risk for contracting COVID-19. Please disclose any condition that compromises your immune system, and please be advised that we may ask you to consider rescheduling treatment or we may recommend palliative and/or non-invasive treatment at this time. It is also important that you disclose any symptoms of or exposure to COVID-19:

Temperature: \_\_\_\_\_ °F    Date: \_\_\_\_\_    Time: \_\_\_\_\_

	Yes	No
Do you have a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19 and are awaiting results?	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled outside our state or outside the US within the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>

**CONSENT**

I have read this form and all of my questions have been answered. I fully understand and acknowledge the risks of receiving care at this time, the cautions regarding a compromised immune system, and I have disclosed all of my health conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate, that I accept the additional risks regarding COVID-19 inherent in receiving dental treatment at this time.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

*Dr. Kaushali Patel*  
\_\_\_\_\_  
Name of Doctor

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date