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: __________________

COVID-19 Screening Form ...

Patient's name:

Date: | **Date:**

PREAPPOINTMENT CHECK | **IN-OFFICE VISIT**

1. Have you previously been diagnosed with COVID-19, or do you think you've had/have COVID-19?

   YES ☐ NO ☐ | YES ☐ NO ☐

   (If NO to question 1, skip to question 5)

2. If YES, when and how were you confirmed positive?
   - ☐ I think I had it.
   - ☐ I had a positive nasal swab test.
   - ☐ I had a positive blood test.
   - ☐ I had a positive saliva test.
   - ☐ I currently have symptoms and am waiting for a test.

3. If you have had COVID-19, how were you confirmed negative?
   - ☐ I was diagnosed negative by a nasal swab test. How many times? How far apart?
   - ☐ I show antibodies to COVID-19 with a blood test.
   - ☐ My doctor said I no longer have it because I don't have any symptoms.
   - ☐ I don't have any symptoms, so I don't have it.

4. If you have had COVID-19, when were you confirmed negative?

   ☐ 24 hours ago ☐ today ☐ 10 days after testing

5. Do you currently have (or have you experienced) any of the following symptoms in the past 21 days:

Symptom	Preappointment check	In-office visit
Fever	YES ☐ NO ☐	YES ☐ NO ☐
	If fever, how did you measure it?	
Fatigue (feeling tired)	YES ☐ NO ☐	YES ☐ NO ☐
Altered or loss of taste/smell	YES ☐ NO ☐	YES ☐ NO ☐
Dry cough	YES ☐ NO ☐	YES ☐ NO ☐
Trouble breathing	YES ☐ NO ☐	YES ☐ NO ☐
Shortness of breath, difficulty breathing, chest tightness	YES ☐ NO ☐	YES ☐ NO ☐
Confusion	YES ☐ NO ☐	YES ☐ NO ☐
Blueish lips or face	YES ☐ NO ☐	YES ☐ NO ☐
Chills/repeated shaking with chills	YES ☐ NO ☐	YES ☐ NO ☐
Muscle pain	YES ☐ NO ☐	YES ☐ NO ☐
Headache or sore throat	YES ☐ NO ☐	YES ☐ NO ☐
Any other flu-like symptoms	YES ☐ NO ☐ PLEASE LIST	YES ☐ NO ☐ PLEASE LIST
GI upset or diarrhea	YES ☐ NO ☐	YES ☐ NO ☐

6. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19–positive?

	YES ☐ NO ☐	YES ☐ NO ☐

7. In the past 14 days have you traveled to any regions affected by COVID-19?

	YES ☐ NO ☐	YES ☐ NO ☐

Some medical conditions have been associated with more severe COVID-19 disease. The following questions are an attempt to determine your risk:

8. Are you over age 65?	YES ☐ NO ☐	YES ☐ NO ☐
9. Do you have high blood pressure?	YES ☐ NO ☐	YES ☐ NO ☐
If you have high blood pressure, is it controlled?		
	YES ☐ NO ☐	YES ☐ NO ☐
10. Do you have diabetes?	YES ☐ NO ☐	YES ☐ NO ☐
11. Are you overweight?	YES ☐ NO ☐ NO ANSWER ☐	YES ☐ NO ☐ NO ANSWER ☐
12. Do you have respiratory problems?	YES ☐ NO ☐	YES ☐ NO ☐
13. Do you have any autoimmune disorders?		
	YES ☐ NO ☐	YES ☐ NO ☐

14. Are there any other conditions you would like to report?