COVID-19 Treatment Consent Form

I, _____, consent to receive dental treatment from McCandless Dental Care, PLLC during the COVID-19 outbreak.

Thank you for your continued trust in our practice. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection and the use of personal barriers, there is still a chance that you could be exposed to an illness. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, dental staff and sometimes other patients at all times.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have a risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest

I confirm that I do not display or currently have any of the symptoms that are representative of COVID- 19, which are outlined above: _____(Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.
I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission in the past 14 days. ____(Initial)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. _____(Initial)

Patient
Name:_____
Patient/Guardian
Signature:_____

Date:_____