COVID-19 Pandemic Dental Treatment Consent Form

Patient Name:_____Patient Temp:_____ Date:_____

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

  _____
  (Initial)
- I understand that dental procedures create water spray in which is one-way COVID-19 can spread. The ultra-fine nature of the spray can linger in the air for minutes, up to hours, which can transmit the COVID-19 virus.

  _____
  (Initial)
- I understand, due to the frequency of visits of other dental patients, that characteristics of the COVID-19 and dental procedures, I have an elevated risk of contracting the virus simply by being in a dental office.

  _____
  (Initial)
- I verify that I have not traveled within the last 14 days via car, air, bus or train. I also understand that any travel state-to-state or outside of the country significantly increases my risk of contracting and transmitting the novel coronavirus. The Federal Government requires self-isolation for a minimum of 14 days from the date a person has returned from their travels.

  _____
  (Initial)
- I certify that I am not currently positive for COVID-19 and not presently waiting on results from a laboratory.

  _____
  (Initial)
- I certify that it is my obligation to notify Bismarck Advanced Dental and Implants of any onset symptoms I may have relating to COVID-19 after being seen.

  _____
  (Initial)
- I certify that I have not been identified as a contact of someone who has tested positive for COVID-19 or been asked to self-isolate by the ND Dept. of Health.

  _____
  (Initial)
- I understand that I am willingly receiving dental treatment from Bismarck Advanced Dental and Implants and am aware of the risks associated with receiving treatment.

  _____
  (Initial)

- Have you experienced a fever or feverish in the last 14-21 days? YES NO
- Are you experiencing shortness of breath or difficulties breathing? YES NO
- Do you have a cough? YES NO
- Are you experiences other flu-like symptoms (upset stomach, headache, or fatigue)? YES NO
- Have you experienced a recent loss in taste or smell? YES NO
- Have you been in contact with any confirmed COVID-19 positive patients? YES NO
- Are you over the age of 60? YES NO
- Do you have an underlying health concerns or auto-immune disorders? YES NO

  If yes, please list:_____

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

_____ _____

(Patient Print) (Patient Signature)