ELITE CARE
DENTAL

COVID-19 Pandemic Dental Treatment Consent Form

Patient Name: _____ Temp & Date: _____

I understand dentistry is not an exact science and there is no guarantee of results. When undergoing dental treatment during the COVID-19 Pandemic there are certain risks and increased potential for infection, in addition to a potential for unsuccessful results from the procedure. I knowingly and willingly consent to receive dental treatment during the COVID-19 pandemic. _____ (Initial).

This dental provider has engaged in all appropriate CDC, state and local health agency recommendations regarding sanitation [as available], personal protective equipment [as available], and safety protocols to slow the spread of COVID-19. _____ (Initial)

In order to minimize these risks, my dental provider is requesting additional information and informed consent from the patient. _____ (Initial)

In order to help keep other patients and dental staff safe and healthy, I am confirming that I do not present with any of the following symptoms of COVID-19: fever, shortness of breath, dry cough, or sore throat. _____ (Initial).

I confirm that I have not been diagnosed with COVID-19 or been in close contact [less than 6ft.] with another person who has been diagnosed or is awaiting results of testing for COVID-19. _____ (Initial).

I understand that COVID-19 has a long incubation period during which the 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 current limitations in virus testing. _____ (Initial)

Dental procedures present the possibility of spreading potentially infected bodily fluids through the water spray. This spray can linger in the air for unknown periods of time, which can cause the unwitting transmission of the COVID-19, regardless of the highest sanitation procedures being followed. _____ (Initial)

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

If I cannot truthfully sign any of the above statements, the dentist has strongly encouraged me to contact my primary physician or public health department to determine if I should be seen or tested before coming in for any dental care. _____ (Initial)

This dental provider reserves the right to contact their local and state health department authorities to report any Patient suspected of having COVID-19. _____ (Initial)

Patient's Signature & Date: _____