Consent for Treatment during COVID-19 outbreak

Patient's Name: _____ Date of Birth: _____

Our goal is to protect the safety of the dental office, our team members, the patients we serve and other individuals who come upon the premises.

Our staff are symptom-free and, to the best of their knowledge have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, without their knowledge. Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. 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, dental staff and sometimes other patients at all times.

Acknowledgment

- I acknowledge that all my questions have been answered to my satisfaction and I consent to the performance of the treatment proposed by my dentist.
- I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office and the patients, staff and other individuals who come upon the premises
- I have been advised that I should seek care from a qualified physician for any medical questions and/or concerns.
- I understand that there is a $15 fee per visit to cover a portion of the increased cost for personal protection equipment. I am responsible for the total amount due today.

Patient/Guardian Signature: _____ Date: _____

Treating Dentist Signature: _____ Date: _____

Witness Signature: _____ Date: _____

This consent form must be signed and on file for each patient receiving treatment.