COVID-19 Pandemic Patient Consent Form

I, _____, knowingly and willingly consent to have dental treatment, including, without limitation, dental hygiene, routine treatment(s) and emergency treatment(s) ("Treatment") completed by _____ (the "Practice") during the COVID-19 pandemic. My receipt of Treatment shall under no circumstances be construed as the Practice requiring and/or mandating that I continue with the Treatment in light of COVID-19, and that my willingness and acceptance to receive the Treatment is my sole and exclusive decision.

I understand COVID-19 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 may or may not have contracted the virus given the current limits in medical testing.

I agree and acknowledge that dental procedures require close contact with others and create water spray, and it is unclear as to how long the ultra-fine nature of the spray may linger in the air, which may transmit the COVID-19 virus.

I have been made aware of guidelines provided by the Center for Disease Control ("CDC"), and state and local authorities, that under the current COVID-19 pandemic, close interaction (e.g., within 6 feet) with individuals and other public outings are not recommended. Any such interaction or public outing should be limited to only essential purposes. _____(INITIAL HERE)

I further acknowledge that dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. As such, I confirm that I am seeking treatment for a condition that meets these criteria or hygiene and/or routine treatment at my sole election. _____(INITIAL HERE)

At this time, I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below: fever, shortness of breath, loss of sense of taste or smell, dry cough, runny nose, or sore throat. I agree and acknowledge that in the event I do present any of the above symptoms, I will take all necessary measures to quarantine myself and limit exposure to others, including, without limitation, providing prompt notification to Practice and rescheduling the Treatment until my symptoms subside. I understand that domestic and/or international travel significantly increases my risk of contracting and transmitting COVID-19, and the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has traveled recently, and this may or may not be possible in performing Treatment. _____(INITIAL HERE)

Additionally, I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____(INITIAL HERE)

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "PATIENT CONSENT FORM" AND FULLY UNDERSTAND THAT IT IS A WAIVER AND RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE THE PRACTICE AND ALL OF ITS AFFILIATES, DENTISTS, OWNERS, DIRECTORS, OFFICERS, MANAGERS, MEMBERS, SHAREHOLDERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST THE PRACTICE FOR PERSONAL INJURY AND/OR PROPERTY DAMAGE STEMMING FROM OR IN RELATION TO CONTRACTING OR BEING DIAGNOSED WITH COVID-19.

Signature_____ Date_____

Print_____