COVID-19 Pandemic Dental Treatment Consent Form

I, _____(the patient), knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understant the COVID-19 virus has a long incubation period during in which 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 the current limits in virus testing. I, the patient, will hold harmless and indemnify, the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions, in exchange for dental treatment during the events of COVID-19 National Emergency from the period of time _May 2020_ to _March 2021_.

I understand that this action is just a business decision and agree this represents a compromise between the patient and the doctor. Accordingly, this agreement is not an admission of any liability regarding the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions. I have carefully read this release and understand its contents and I am signing it of my own free act.

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

I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below

- Fever
- Shortness of Breath
- Dry Cough
- Runny nose/sinus infection
- Sore throat
- _____(initials)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus and the CDC recommends social distancing of at least 6 feet for period of 14 days to anyone who has, and this is not possible with dentistry. _____ (Initials)

- I verify that I have not traveled out the United States in the past 14 days to countries that been affected by the COVID_19. _____(Initials)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____(Initials)

- **Patient/Guardian**

Signature: _____ Date: _____