COVID-19 Dental Treatment Consent Form

I,_____, knowingly and willingly give consent for myself or my dependent _____, to have dental treatment completed during the COVID-19 pandemic.

_____**initial**

Furthermore, I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Shortness of breath
- Dry Cough
- Sneezing / Runny nose
- Sore Throat
- Fatigue
- Sweating

_____**initial**

If, at any point in the next 14 days, I being to exhibit symptoms of the COVID-19 virus, I will inform the practice immediately and will inform them of any testing results or quarantine orders I receive from a medical physician. I understand this continues communication with the practice is essential to help to curb the spread of the virus and to allow the practice to provide informed consent to other patients and to otherwise take protective measures. I understand the practice will not share of disseminate any of my protected health information for any unlawful or prohibited purpose.

_____**initial**

Patient Name:_____

Signature:_____

Date:_____