

Informed Consent for Dental Treatment- COVID 19

You have elected to receive dental care during the COVID19 National Emergency on the grounds that you feel the need for treatment is urgent. In addition to the standard risks associated with any dental procedure or treatment, please be advised that there may be heightened risk of infection with the virus arising from being in close contact with dentists, patients, or staff.

By signing below, you indicate that you wish to proceed with treatment today and that:

1. You have discussed with your provider the risks vs. the benefits of proceeding at this time with treatment, rather than rescheduling to a time when the risk of infection from the virus may be substantially lower.
2. You understand that while the practice has taken precautions to limit the spread of the virus, there is still a possibility of transmission that may arise from your receipt of treatment.
3. You have had an opportunity to consider whether you or any member of your household is at high risk of serious consequences should you become infected with the virus. See <http://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications/html> .
4. You agree to inform our office if you/your child develop symptoms related to COVID-19 within 14 days of your visit to our office.

If patient is under 18

Patient Name: _____

Parent/Guardian Signature: _____

Patient Name: _____

Patient Signature: _____

Date: _____