Patient Advisory and Acknowledgement

Receiving Dental Treatment During the SARS-COV-2 Pandemic

You have presented to the office today for dental treatment. While our office complies with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the SARS-COV-2 virus, we cannot make guarantees. Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus and are fully vaccinated. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

I, _____ **(your name)**, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus 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 has it and who does not, given the current limits in virus testing. Dental procedures create water spray. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus. I understand that CDC recommends social distancing of at least 6 feet apart and this is not possible with dentistry. _____ **(initial)**.

In order to reduce that risk of spreading SARS-COV-2, we have asked you several "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

Please answer "Yes" or "No" with your <u>initials</u>, to the following questions:

- Have you received your COVID-19 vaccination (both doses)? _____Yes _____No
- Do you have a fever? _____Yes _____No
- Do you have any shortness of breath? _____Yes _____No
- Do you have dry cough? _____Yes _____No
- Do you have any other flu-like symptoms? _____Yes _____No
- Have you experienced recent loss of taste or smell? _____Yes _____No
- Contact with any confirmed COVID-19 positive people? _____Yes _____No
- Within the last 14 days:
  Have you travelled to any foreign country or within the US? _____Yes _____No

_____

Patient/Responsible Party Date