

# Patient Advisory and Acknowledgment

## 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 any guarantees. Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

I, \_\_\_\_\_, 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 the 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 initials, to the following questions:

Do you have a fever? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any shortness of breath? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have a 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

If so, where? \_\_\_\_\_

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Patient/Responsible Party

Date