COVID-19 NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Date:
Patient name:
DOB:

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.
You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of any potential risks of contracting COVID-19 associated with dental care. COVID-19 is carried by respiratory droplets. Since many dental procedures create aerosols, these droplets can be a concern to carry the virus. Be assured that our office has taken precautions to minimize your risk and any potential exposure. While this dental office has taken significant steps to improve protocols and techniques to minimize risk in accordance with CDC and ADA guidelines, no medical or dental procedure is without risk. The potential transmission of the COVID-19 virus must remain a consideration at this time.

I confirm that I understand the potentially heightened risk associated with dental treatment at this time. I also confirm that I understand the reasons why dental offices may pose a higher risk. I, as the patient, should have the expectation that every effort will be made to help minimize those risks.
I have read and understand the information stated above.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:
- Fever (100 degrees or greater)
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- _____ (Initial)

- I verify that I have not traveled outside of the United States in the past 14 days to countries that have been affected by COVID-19. _____ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____ (Initial)

I have <u>not</u> had "close contact" with an individual diagnosed with COVID-19 in the last 14 days. "Close Contact" means living in the same household as a person who has tested positive for COVID-19 or being within 6-feet of a person who has tested positive for COVID-19 without a mask on for more than 10 minutes _____ (Initial)

_____ _____
Patient (or Legal Guardian) Signature Date