COVID-19 Dental Treatment Consent Form

I, ________________________, knowingly and willingly consent to have
(circle an option - preventive, elective, restorative, emergency) dental treatment completed during to 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 the virus and who does not given the current limits in testing.

Dental procedures create water spray which is how the disease is spread. The ultra find nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.________ (initial)

- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommend social distancing of at least 6 feet for a period of 14 days to anyone who has traveled by air. Social distancing is not possible during dental treatment.________ (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)

____ ____________________

Signature patient or parent/guardian Date

River Forest Dental Studio COVID-19 Patient Screening Questionnaire

*Indicate Yes or No and provide relevant comments.

Patient Name: ______________________________ Date: ______________

Screening Questions	Pre-Appointment*	In-Office*	Post-Appointment* Patient self-reports within 14 days after appointment, if symptoms or diagnosis of COVID-19
Do you have a fever, or have you felt feverish recently?			
Do you have a cough?			
Are you having shortness of breath or any difficulty breathing?			
Do you have chills or repeated shaking with chills?			
Do you have any muscle pain?			
Do you have any recent onset of headache or sore throat?			
Do you have any other flu-like symptoms?			
Do you have any recent loss of taste or smell?			
Have you experienced any recent GI upset or diarrhea?			
Are you in contact with anyone who has been confirmed to be COVID-19 positive?			
Have you traveled in the past 14 days to any regions affected by COVID-19?			
Have you been tested for COVID-19? If yes, what was the result?			
Have you been diagnosed with COVID-19? If yes, when?			
Are you over the age of 65?			
Do you have: Heart disease Lung disease Kidney disease Diabetes Autoimmune disorders			