## Dental Treatment Consent and Affirmation Form COVID-19 Reopening

1.	I knowingly and willingly consen	t to dental treatment at	by Dr	
	And any designated associates and	d employees during the reopenir	ng phase of COVID-19.	
2.	understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show ymptoms yet are still highly contagious. It is impossible to determine who has COVID-19 and who does not given ne current limitations and availability in COVID-19 viral testing.			
3.	the virus, and the characteristics of	and that due to the frequency of visits of other care dental patients, characteristics of of dental procedures, that I have an elevated risk of contracting the virus simply by ough standard precautions are being observed.		
4.	I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:  A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher  B. Shortness of breath  C. Dry cough  D. Runny nose  E. Sore throat.  F. Diminished sense of taste or smell			
5.	Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in paragraph 4 (#4) in the last 14 days.			
6.	Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.			
<b>INFORMED CONSENT</b> : I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.				
Patient's name (please print)		Signature of patient, legal guardia	n or authorized representative	Date
Witness to signature		Date		