COVID-19 Dental Treatment Consent Form

I, _____, consent to receive treatment from Andrew C. Dreyer, DDS, MS during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19, the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Persistent pain or pressure in the chest
- Loss of smell or taste
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above.

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days.

I confirm that if I develop symptoms consistent with COVID-19 within 14 days of my appointment, I will notify Dr. Dreyer's office immediately.

Patient/Guardian Signature:_____

Date:_____

Doctor Signature:_____

Date:_____