DentalBright
advanced family dentistry & orthodontics

COVID-19 Pandemic Emergency Dental Treatment Consent Form

I, _____, knowingly and willingly consent to having emergency 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. Given the current limits in virus testing, it is impossible to determine who has it and who does not have COVID-19. Dental procedures create water spray (aerosols), which is one way the disease can be spread.

I understand that Dental Bright is providing the safest possible environment with improvements in high speed suction, extra-oral vacuums, air purifiers and deep cleanings between patients with either disinfecting fogging or UVC light treatments.

- ✔ I understand that due to the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus even with the utmost and most stringent precautions. _____ (Initial)
- ✔ I have been made aware that Dental Bright adheres to and in many ways surpasses the recommendations of the Centers for Disease Control and Prevention (CDC) and American Dental Association (ADA) guidelines.
  Dental visits should be limited to the treatment for or prevention of: pain, infection/disease and conditions that inhibit normal operation of teeth and mouth. Oral hygiene visits have significant importance during this time and therefore are included. _____ (Initials)
- ✔ I confirm I am seeking treatment for a condition that meets these criteria. _____ (Initials)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below: _____ (Initials)

- Fever
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat

The CDC recommends social distancing of at least 6 feet for a period of 14 days around anyone who has traveled by air, and this distance is not possible with dentistry. _____ (Initials)

- ✔ I have/have not (circle one) traveled by commercial airline, bus, or train within the past 14 days. _____ (Initial)
- ✔ I knowledge that I should contact Dental Bright Immediately if I have any of the symptoms listed above that are suspicious of COVID-19, in the next 14 days. . _____ (Initials)

Signature _____ Date _____